

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11737

11750

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 305 PULASKI ST.	
3. NAME OF DECEASED (Type or print) First JOHN Middle WAYNE Last ALDERTON		4. DATE OF DEATH Month 09 Day 17 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04-23-08
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY SAVOY BOWLING CO.	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, ALLEGANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CECIL ALDERTON		14. MOTHER'S MAIDEN NAME Bartha TROUTMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-7089	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cochexia 147X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Coccioidosis DUE TO (c) Coccioidosis of Pyropharynx		INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March , 1967, to 9/17 , 1967, that (I) (we) last saw the deceased alive on 9/19 1967, and that death occurred at 4:45 PM , from causes and on the date stated above.			
22a. SIGNATURE J.A. PAGAN, M.D.		22b. DATE SIGNED 9/18/67	
22c. PHYSICIAN'S NAME (Type) J.A. PAGAN, M.D.		22d. ADDRESS 5 POTOMAC STREET, RIDGELEY, W.VA.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/20/67	
23c. NAME OF CEMETERY OR CREMATORY Hilbert Burial Pl.		23d. LOCATION (City or Town) (County) (State) Cumberland Md	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		25a. REC'D BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



ALLERBY

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3 DAYS

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305 BUL 241 ST.

2 GREEN HEART HOSPITAL

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24 07 24 11 3 00. CUTBELL AND, ALLERBY, W.S.A.

CLERK

TR OUTMAN

CECIL LIDERTON

HOSPITAL RECORD

2 1-02-70

NO

2 POTOMAC STREET, HIOBELLY, W.V.

J.A. PIERCE, H.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb 15 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS FROSTBURG, RT. 1,	
3. NAME OF DECEASED (Type or print) GEORGE R. ALDRIDGE		4. DATE OF DEATH Month SEPTEMBER Day 2, Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 25, 1895
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MAINTENANCE		10b. KIND OF BUSINESS OR INDUSTRY REFRACTORY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE L. ALDRIDGE		14. MOTHER'S MAIDEN NAME AMANDA E. REED	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-12-2367	
17. INFORMANT MARIE S. ALDRIDGE, RT1, FROSTBURG, MD.		Address BOX 244	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Art. C.V.D. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Advanced Pulmonary insufficiency due to		INTERVAL BETWEEN ONSET AND DEATH 15 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1966 , to 9/2, 1967 , that (I) (we) last saw the deceased alive on 7/2, 1967 , and that death occurred at 2:00 M, from causes and on the date stated above.			
22a. SIGNATURE Martin Rothstein M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.		22b. DATE SIGNED 9/2/67	
22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR SEP 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



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11739

CERTIFICATE OF DEATH

11752

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 609 HILLTOP DRIVE		d. STREET ADDRESS 609 HILLTOP DRIVE	
3. NAME OF DECEASED (Type or print) First Middle Last RHODA E. G. AMBROSE		4. DATE OF DEATH Month Day Year SEPT. 5 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 26, 1881
9. AGE (In years lost birthday) 85 Yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) ORLEANS CROSSROADS, W. VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN R. SHIPLEY	
14. MOTHER'S MAIDEN NAME NANCY DAWSON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT NANCY S. AMBROSE Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 4500 DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs 15 pm-
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-1-1967 to 9-5-1967 , that (I) (we) last saw the deceased alive on 9-5-1967 , and that death occurred at 5 PM , from causes and on the date stated above.			
22a. SIGNATURE H. W. ELIASON		22b. DATE SIGNED SEPT. 6, 1967	
22c. PHYSICIAN'S NAME (Type) H. W. ELIASON, M.D.		22d. ADDRESS 203 GREENE ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF SEPT. 8, 1967	23c. NAME OF CEMETERY OR CREMATORY CAMP HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) PAW PAW W. VA.
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR SEP 11 1967	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR A15 (4)
25M 1/67

11740

11753

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 3WHS. 5DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CORA First F. Middle ARNOLD Last		4. DATE OF DEATH Month SEPTEMBER Day 17 Year 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1882
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWFE.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CABRIAL FEASTER		14. MOTHER'S MAIDEN NAME CATHERINE MAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) terminal Cordiac failure DUE TO (b) A.S. & Hypertensive Cardiovascular disease DUE TO (c) Gen. arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 weeks 3 years ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus 1 med. mod. since 1956,		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 23 Aug , 19 67 to 17 Sept , 19 67 , that (I) (we) last saw the deceased alive on 16 Sept , 19 67 , and that death occurred at 4:15 A.M. on 17 Sept , 19 67 , and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer		22b. DATE SIGNED 17 Sept. 67	
22c. PHYSICIAN'S NAME (Type) DR. VAN ORMER		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9-19-67	23c. NAME OF CEMETERY OR CREMATORY Judson Mount	23d. LOCATION (City or Town) (County) (State) Romney Hampshire N.C.
24. FUNERAL DIRECTOR Earl B. Thurston		25a. REC'D BY REGISTRAR Moorefield N.C.	
25b. REGISTRAR'S SIGNATURE		DATE SEP 22 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11741		CERTIFICATE OF DEATH	
11754			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 40 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		d. STREET ADDRESS 411 CENTRAL AVENUE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVA Middle MYRTLE Last ASHBY		4. DATE OF DEATH Month SEPT. Day 19 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-96
9. AGE (In years lost, give day) 70 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL MAID SERVICE		10b. KIND OF BUSINESS OR INDUSTRY MRS. WM. BIBBY	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ISAAC JOHNSON		14. MOTHER'S MAIDEN NAME XX MARIA HICKMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-20-5417	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer - Intestinal Tract DUE TO 159x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension C.V. Disease DUE TO 159x (c) 159x		INTERVAL BETWEEN ONSET AND DEATH 159x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 1950 to Sept 19, 1967 that (I) (we) last saw the deceased alive on Sept 19, 1967 , and that death occurred at 2:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE B. Schindler		22b. DATE SIGNED 9/20/67	
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/22/1967	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Md.
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

MD

1191
ALLEGANY
CHESBROUGH
10 DAYS
111 CENTRAL AVENUE
19 27
13-2-08
W. VIRGINIA
KY. MOUNTAIN HICKORY
MEMORIAL HOSPITAL CHESBROUGH, MD.

2:30P
DR. L. SCHINDLER
CHESBROUGH, MD.
SEP 24 1908

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

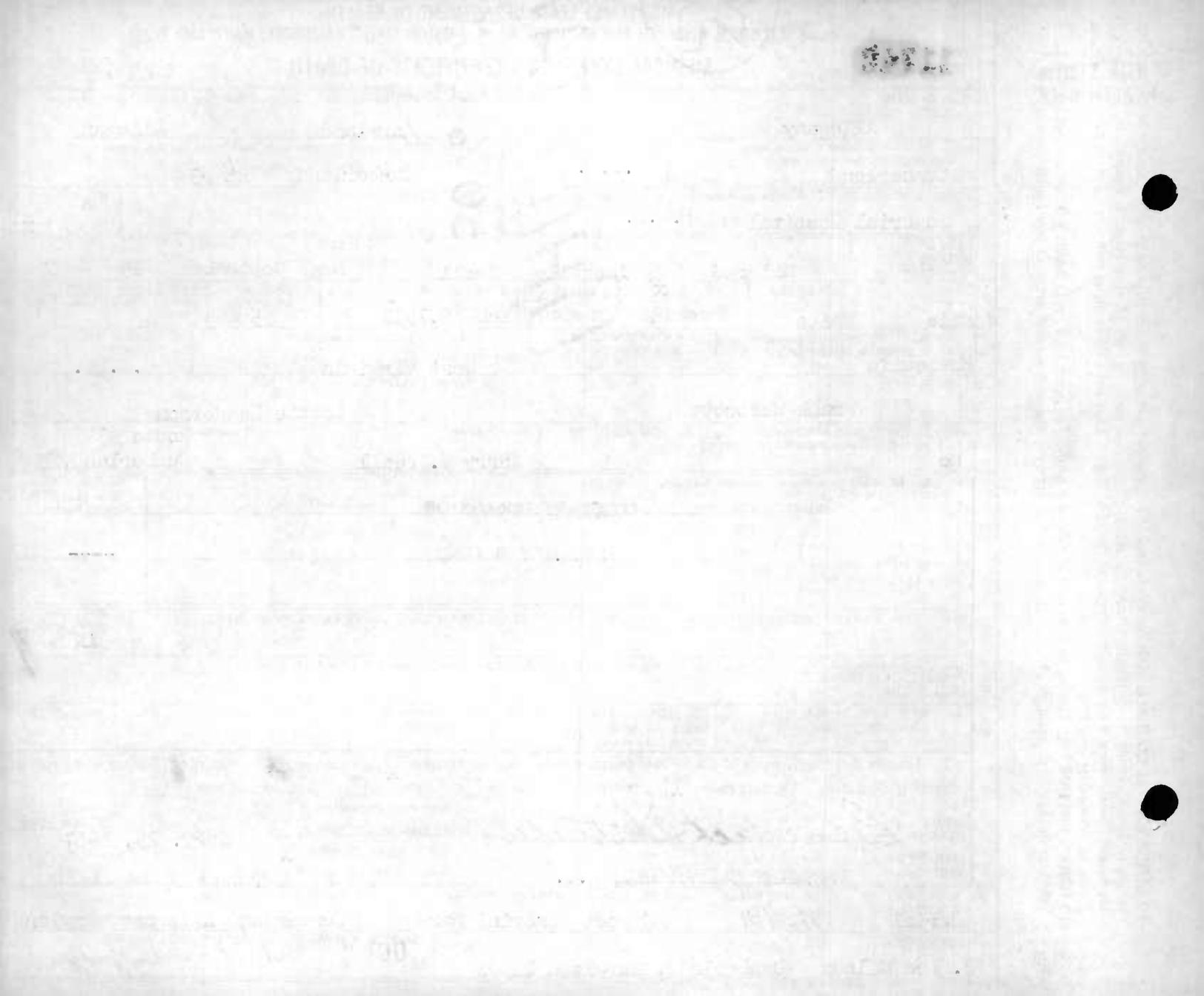
11742

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11755

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital D.O.A.		d. STREET ADDRESS Cumberland Rt #3	
3. NAME OF DECEASED (Type or print) First Mildred Middle Isabelle Last Beall		4. DATE OF DEATH Month September Day 25 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 19, 1912
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 55 Days 25 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Westcott		14. MOTHER'S MAIDEN NAME Lottie Henderson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Harry W. Beall	
17. INFORMANT Route #3		Address Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) -----			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarellic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/28/67	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS Cumberland, Maryland 21502	
25a. REC'D BY REGISTRAR OCT 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11748

CERTIFICATE OF DEATH

11756

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb Gilmore (Rural Midland)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		d. STREET ADDRESS 11756	
3. NAME OF DECEASED (Type or print) First CHARLES Middle H Last BEEMAN		4. DATE OF DEATH Month 9/3/1967 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17th. 1903 9. AGE (In years lost birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gilmore, Md.	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Beeman		14. MOTHER'S MAIDEN NAME Mary Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 11748	
17. INFORMANT Mrs. Dewey Shroyer, Salisbury, Pa.		Address Salisbury, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic obstructive pulmonary disease		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
21. I certify that (I) (this hospital) attended the deceased from Aug 14, 1967 to Sept 3, 1967 that (I) (we) last saw the deceased alive on Sept 3, 1967 , and that death occurred at 3:00 PM , from causes and on the date stated above.		22a. SIGNATURE A. Paige Strong 22c. PHYSICIAN'S NAME (Type) A. Paige Strong	
22b. DATE SIGNED Sept. 4, 1967		22d. ADDRESS Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/6/1967	
23c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery		23d. LOCATION (City or Town) (County) (State) Midland, Md.	
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR SEP 6 1967 25b. REGISTRAR'S SIGNATURE James Judge	

1000

STATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11744

CERTIFICATE OF DEATH

11757

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/12/1966	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 220 Greene Street	
3. NAME OF DECEASED (Type or print) First Albert Middle Richard Last Bender		4. DATE OF DEATH Month September Day 12 Year 1967	
SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Bender		14. MOTHER'S MAIDEN NAME Mary A. Gessner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-6913	
17. INFORMANT: P.O. Box 599, Cumberland, Md. 21502		18. ADDRESS: Allegany County Infirmary records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Acute renal insufficiency DUE TO (b) chr. ASH D DUE TO (c) Arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/12/ , 19 66 , to 9/12/ , 19 67 ; that (I) (we) last saw the deceased alive on 9/12/1967 , 19 67 , and that death occurred at P. M. , from causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED Sep 13 - '67	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/15/67	
23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR SEP 18 1967	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE James Judge	

1174

11/11/1956

Albany

Albany

Albany

Albany

11/11/1956

Albany

320 Greene Street

Albany County Jail

Albany, New York, December 11, 1956

11/11/1956

Albany, New York, December 11, 1956

Albany, New York, December 11, 1956

Albany, New York, December 11, 1956

Albany, New York, December 11, 1956

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Albany, New York, December 11, 1956

Albany, New York, December 11, 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20 M 1/66

11745

CERTIFICATE OF DEATH

11758

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 40 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONERS HOSPITAL		d. STREET ADDRESS 65 EAST MAIN STREET	
3. NAME OF DECEASED (Type or print) First Middle Last ANNA MAE BENNETT		4. DATE OF DEATH Month Day Year SEPT. 9, 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11, 1890
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) LONA CONING, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SEGGIE		14. MOTHER'S MAIDEN NAME SARAH FOUTZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N.A.		16. SOCIAL SECURITY NO. 220-10-2646	
17. INFORMANT MRS. WILLIAM CRABLE, 16 WATERELIFF ST		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage DUE TO (b) Hypertensive Arteriosclerotic CVD DUE TO (c) 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State) X	
21. I certify that (I) (this hospital) attended the deceased from APRIL, 1964 , to 9/9, 1967 , that (I) (we) last saw the deceased alive on 9/9, 1967 , and that death occurred at 8:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein		22b. DATE SIGNED 9/11/67	
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M.D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 11, 1967	
23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK FROSTBURG		23d. LOCATION (City or Town) (County) (State) MARYLAND	
24. FUNERAL DIRECTOR MARILOU M. SOWERS, HAVER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG		25a. REC'D BY REGISTRAR SEP 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1947

STATEMENT OF DEBIT

DEBIT

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TO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
11746											
CERTIFICATE OF DEATH											
11759											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						d. STREET ADDRESS 16 STANDISH STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT FRANKLIN BITTNER						4. DATE OF DEATH Month Day Year SEPTEMBER 19 19 67					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-10-1922		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) POST OFFICE				10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV.		11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MD.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LOUIS J. BITTNER						14. MOTHER'S MAIDEN NAME ZILPHA THOMAS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W. WAR II				16. SOCIAL SECURITY NO. 215-14-6343		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cardiac arrest 4330 DUE TO (b) Myocardial Infarction, coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Myocardial Infarction Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 19 Sept 67 22 Aug 64 7 Sept 63											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (a) A.S. Cardiovascular disease?										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7 Sept , 19 63 , to 19 Sept , 19 67 , that (I) (we) last saw the deceased alive on 14 Sept , 19 67 , and that death occurred at 1:28 AM , from causes on and on the date stated above.											
22a. SIGNATURE W. A. Van Ormer						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER						22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		SEPT. 21, 1967		FINZEL CEMETERY		FINZEL GARRETT MD.					
24. FUNERAL DIRECTOR MARILOU M. SOWERS HAFER-SOWERS FUNERAL						25a. REC'D BY REGISTRAR SEP 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

(M)

11747

11760

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 30 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 46 PAXTON STREET	
3. NAME OF DECEASED (Type or print) First ALBERT Middle H. Last BLAND		4. DATE OF DEATH Month SEPT. Day 15 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-17-1885
9. AGE (In years and months) 82 yrs.		10. IF UNDER 1 YEAR Months 8 Days 15 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (County & State, or foreign country) W. WARREN, W. VA.		12. CITIZEN OF WHAT COUNTRY? U. A. A.	
13. FATHER'S NAME OLIVER BLAND		14. MOTHER'S MAIDEN NAME SARAH A. MYERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 years (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate Pulmonary embolism			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 16, 1967 , that (I) (we) last saw the deceased alive on 15 Sept 1967 , and that death occurred at 11:20 A.M. , from causes and on the date stated above.			
22a. SIGNATURE W. G. Weisman M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22b. DATE SIGNED 16 September 1967			
22c. PHYSICIAN'S NAME (Type) DR. W. G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/18/1967	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing A. Md.	
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR Lonaconing, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 19 1967	

11-11-88

MINERAL W. VIRGINIA

WRIGHT

TO DAVIS

CLINTON

IN PARTIAL 21 FEET

MEMORIAL HOSPITAL

ALBERT

STAND

SENT

WAGE WHITE

1-11-1988

EX

W. WARE, W. VA. U. A. A.

JOE HEN

WALTER KIRBY

SARAH A. WELLS

OLIVER BEARD

MEMORIAL HOSPITAL - CUMBERLAND, MD.

11:30 A.M.

22 GREENE ST., CUMBERLAND, MD.

DR. W. S. WELLS

MEMORIAL HOSPITAL

W. VA. U. A. A. W. VA. U. A. A.

W. VA. U. A. A.

MEMORIAL HOSPITAL, 22 GREENE ST., CUMBERLAND, MD.

MEMORIAL HOSPITAL

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

11748

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11761

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Race Street			d. STREET ADDRESS 3 Race Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle Carl Last Bloss			4. DATE OF DEATH Month Sept. Day 29 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1908	9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Seibert, Md.	
13. FATHER'S NAME John Michael Bloss			14. MOTHER'S MAIDEN NAME Maude Twigg		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War II		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Eugene Pendergast, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH Sudden --
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		9-29-67	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED Rt. 9 Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 2, 1967		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
		25a. REC'D BY REGISTRAR OCT 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove within 72 hours after death. should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #2c & d Film #G392 9/21/67 ph									
11749									
11762									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND			c. LENGTH OF STAY IN 1b 1 MONTH 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONGVIEW / Cumberland 01/7				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL					d. STREET ADDRESS Fort Cumberland Hotel KYLE NURSING HOME			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LENA N BOHON					4. DATE OF DEATH Month SEPTEMBER Day 13 Year 1967				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 13, 1897		9. AGE (In years lost birthday) yrs. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - Restaurant Employee			10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT			11. BIRTHPLACE (County & State, or foreign country) TUCKER, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM BOHON					14. MOTHER'S MAIDEN NAME OLIVE JEANETTE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 216-22-6076		17. INFORMANT HOSPITAL RECORD Address 900 SETON DRIVE,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphocytic leukemia DUE TO 2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8-6-67 , 19 67 , to 9-13 , 19 67 that (I) (we) last saw the deceased alive on 9-13 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above.									
22a. SIGNATURE L. Brings					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 9-14-67	
22c. PHYSICIAN'S NAME (Type) DR. LEWIS BRINGS					22d. ADDRESS 57 GREENE STREET, CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.					25a. REC'D BY REGISTRAR SEP 18 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11750

CERTIFICATE OF DEATH

11763

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 4/18/67	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lucinda Scott Bond		4. DATE OF DEATH Month Day Year September 24, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/1887
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adam Scott		14. MOTHER'S MAIDEN NAME Jane Nichols	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599, Cumberland, Md. 21502		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma sigmoid & rectum DUE TO (b) Metastasis DUE TO (c) Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour :o.m. :p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> or work or work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/18/67 , 19__, to 9/24/67 , 19__, that (I) (we) last saw the deceased alive on 9/24/67 , 19__, and that death occurred at P. M. , from causes and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE SIGNED 9/25/1967	
22c. PHYSICIAN'S NAME (Type) George M. Simons, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-27-67	23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR DATE SEP 29 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

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11751

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 on the reverse of this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		d. STREET ADDRESS Water Station Run	
3. NAME OF DECEASED (Type or print) First Middle Last James Dewey Buskirk		4. DATE OF DEATH Month Day Year September 20 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/1898
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Minister		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Buskirk		14. MOTHER'S MAIDEN NAME Laura Buskirk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Rose Buskirk		Address Lonaconing, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia DUE TO (b) Cardiomegaly DUE TO (c) Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Pulmonary Fibrosis, Emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 19 19 67 to Sept. 20 19 67 , that (I) (we) last saw the deceased alive on Sept. 19 19 67 , and that death occurred at 2 A M, from causes and on the date stated above.			
22a. SIGNATURE L.R. Miles, Jr.		22b. DATE SIGNED 9.21.67	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22d. ADDRESS LONACONING, MD. 21539	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/22/1967	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland A. Md	
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR Lonaconing, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. SEP 22 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11752			
CERTIFICATE OF DEATH			
11765			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 6 1/2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS RT. #1.	
3. NAME OF DECEASED (Type or print) GERTRUDE First Middle Last B. BUTLER		4. DATE OF DEATH Month Day Year SEPTEMBER 1, 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 78 yrs.
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSHUA CANTERBERRY		14. MOTHER'S MAIDEN NAME ELIZA SHULTZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 206-40-7774	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 <i>mesenteric artery occlusion</i> DUE TO (b) <i>arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis Heart Disease & severe coronary disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/26 , 19 67 , to Sept 1 , 19 67 , that (I) (we) last saw the deceased alive on 9/1 , 19 67 , and that death occurred at 11:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Allessman</i>		22b. DATE SIGNED 2 Sept 1967	
22c. PHYSICIAN'S NAME (Type) DR. WEISMAN		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 6, 1967	
23c. NAME OF CEMETERY OR CREMATORY Grandview Memorial Park		23d. LOCATION (City or Town) (County) (State) Ravenna Portage Ohio	
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pennsylvania		25a. REC'D BY REGISTRAR SEP 7 1967	
		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11752												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												11766											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY																							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND						c. LENGTH OF STAY IN lb 12 DAYS						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND																							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL						d. STREET ADDRESS 314 INDEPENDENCE ST.,						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First REBECCA Middle Z. Last CESSNA												4. DATE OF DEATH Month SEPT. Day 9 Year 1967																							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 1922 FEB. 2, 1922				9. AGE (In years last birthday) yrs. 45				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE						10b. KIND OF BUSINESS OR INDUSTRY OWN HOME						11. BIRTHPLACE (County & State, or foreign country) MARYLAND						12. CITIZEN OF WHAT COUNTRY? U. S. A.																	
13. FATHER'S NAME FRANK GOOSH						14. MOTHER'S MAIDEN NAME BESSIE POWELL																													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)						16. SOCIAL SECURITY NO. NONE						17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (a) Uterine DUE TO Uteral obstruction - bilateral (b) Ca cervix DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)																	
21. I certify that (I) (this hospital) attended the deceased from July , 19 66 , that (I) (we) last saw the deceased alive on Sept 8 , 19 67 , and that death occurred at 12:05 P.M. , from causes on and on the date stated above.																																			
22a. SIGNATURE W. Royce Hodges												M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22b. DATE SIGNED SEPT. 25, 1967											
22c. PHYSICIAN'S NAME (Type) DR. W. ROYCE HODGES												22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD																							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						23b. DATE THEREOF SEPT. 12, 1967						23c. NAME OF CEMETERY OR CREMATORY PETER & PAUL CEMETERY						23d. LOCATION (City or town) (County) (State) CUMBERLAND, MD.																	
24. FUNERAL DIRECTOR BYRON KIGHT												CUMBERLAND, MD.												25a. REC'D BY REGISTRAR DATE OCT 2 1967						25b. REGISTRAR'S SIGNATURE Charles Judge					

11753

ALLEGANY

CUMBERLAND

THE HOSPITAL

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DR. A. ROYCE HODGES

DR. A. ROYCE HODGES

FOR STATE
HEALTH DEPT.

11754

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11767

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. LENGTH OF STAY IN lb <u>20 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Monford</u> First Middle Last <u>Clapp</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1891</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>01</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. metal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Fibres,</u>	
11. BIRTHPLACE (State or foreign country) <u>Greensboro, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jasper A. Clapp</u>		14. MOTHER'S MAIDEN NAME <u>Anna Whitehead</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes, U. S. # 1</u>		16. SOCIAL SECURITY NO. <u>214-07-0490</u>	
17. INFORMANT <u>Mrs. Ethel P. Clapp</u>		Address <u>648 Fayette St. Cumb. Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443 X</u> <u>CEREBRAL HEMORRHAGE</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH HOURS <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home; farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		9/27/67 22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		Rt. # <u>9</u> <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany Md.</u>
24. FUNERAL DIRECTOR <u>H. Wayne George Cumberland, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>OCT 2 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11755

11768

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6WKS 1/2 DAY	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS KELLY BLVD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MURIEL R		4. DATE OF DEATH SEPTEMBER 21, 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-13-1893
9. AGE (In years, lost years) 74 yrs.		IF UNDER 1 YEAR: Months 7 Days 21 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MOOREFIELD, W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES E. RALSTON		14. MOTHER'S MAIDEN NAME IDA B. SMITH MONGOLD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-52-9797	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia secondary to DUE TO Multiphase Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Chronic brain syndrome 2° arteriosclerosis (b) Chronic brain syndrome 2° arteriosclerosis (c) Chronic brain syndrome 2° arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 hours 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 , 19 67 , at 6:05 A.M. , that (I) (we) last saw the deceased alive on 19 , 19 67 , and that death occurred at 6:05 A.M. , from causes and on the date stated above.			
22a. SIGNATURE DR. MILTENBERGER		22b. DATE SIGNED 9/23/67	
22c. PHYSICIAN'S NAME (Type) DR. MILTENBERGER		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/23/1967	
23c. NAME OF CEMETERY OR CREMATORY Loom Cemetery		23d. LOCATION (City or Town) (County) (State) Near Augusta, Hampsh W. Va.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR SEP 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1135

STATE OF NEW YORK

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

OWNS ROAD

CUMBERLAND

KELLY ROAD

MEMORIAL HOSPITAL

MURIEL

DAVIDSON

2-13-1923

FEMALE WHITE

ROBERTSON, W. W.

CHARLES E. RALSTON

IDA H. RALSTON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

4:02 A.M.

CUMBERLAND, MARYLAND

DR. HILFENBERGER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11756 CERTIFICATE OF DEATH 11769

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
c. LENGTH OF STAY IN 1b 50 years				d. STREET ADDRESS 604 Louisiana Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 604 Louisiana Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Benjamin Middle C. Last Divico				4. DATE OF DEATH Month Sept. Day 20 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 29, 1887	
9. AGE (In years last birthday) 79		10. AGE (In years last birthday) 79		11. BIRTHPLACE (County & State, or foreign country) Ceccano, Italy		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafe & Restaurant				10b. KIND OF BUSINESS OR INDUSTRY Self Employed			
13. FATHER'S NAME Paul A. Divico				14. MOTHER'S MAIDEN NAME Anna M. Diana			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. War I			
17. INFORMANT Mr. Joseph F. Divico, Cumberland, Md.				18. Address Son			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157X DUE TO Carcinomatous Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Haemia				INTERVAL BETWEEN ONSET AND DEATH 2 yrs 6 mos 3 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Mar , 19 67 , to Sept 20 , 19 67 , that (I) (we) last saw the deceased alive on Sept. 19 , 19 67 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Clay E. Durrett M.D.				22b. DATE SIGNED Sept. 26, 1967			
22c. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, M.D.				22d. ADDRESS 236 Virginia Ave., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 23, 1967		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR SEP 25 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge							

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FOR STATE HEALTH DEPT

EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPT. OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11757

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11770

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. O. A. Sacred Heart Hosp.</u>		e. STREET ADDRESS <u>Brant Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Josef</u> Last <u>Dixon</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1966</u>
9. AGE (In years last birthday) <u>0</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None, Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Fort Jackson, So. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harold J. Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Gudrun Hofmann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Harold J. Dixon</u>		Address <u>Brant Rd. Cresaptown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>9360</u> IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Strangulation in Play Pen</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Impinged on stroller pushed sideways in crib by an older child.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>12:30</u> p.m. <u>Sept. 3</u> 19 <u>67</u>	20d. INJURY OCCURRED <u>2</u> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Cresaptown, Allegany, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>September 3, 1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>Cumberland, Maryland.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany, Md.</u>
24. FUNERAL DIRECTOR <u>H. Wayne George</u> <u>Cumberland, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 7 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11707

Barrett & Lister

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11758

CERTIFICATE OF DEATH

11771

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb 1 WEEK	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 163 MAPLE STREET	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NELLIE Middle COLLINS Last ENGLE		4. DATE OF DEATH Month SEPT. Day 18 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 5, 1877
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) BORDEN MINES, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FRANCIS M. SKIDMORE	
14. MOTHER'S MAIDEN NAME JEANNETTE SLOAN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO	
16. SOCIAL SECURITY NO. 220-52-9803		17. INFORMANT MRS. JAMES MC NEIL, JR., 106 1/2 MAPLE ST. FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage. DUE TO (b) Hypertensive arteriosclerotic vascular disease. DUE TO (c) 30 yrs.			INTERVAL BETWEEN ONSET AND DEATH 9 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Sept 9, 1967	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Sept 9, 1967 to Sept 18, 1967 , that (I) (we) last saw the deceased alive on Sept 18, 1967 , and that death occurred at 7:35 PM , from causes and on the date stated above.	
22a. SIGNATURE Alvin J. Walters		22b. DATE SIGNED Sept 29, 1967	
22c. PHYSICIAN'S NAME (Type) ALVIN J. WALTERS, M.D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MARYLAND	
24. FUNERAL DIRECTOR MARILOU M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG		25. RECEIVED BY REGISTRAR SEP 25 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11759

CERTIFICATE OF DEATH

11772

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 80 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		d. STREET ADDRESS JANE FRAZIER VILLAGE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BLANCHE First Middle Last		4. DATE OF DEATH SEPT. 3 19 67 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-82
9. AGE (In years last day) 85 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) ALLEGANY -- MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AARON STALLINGS		14. MOTHER'S MAIDEN NAME MARY ETTA DANIELS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-52-9805	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4500 IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO (b) Arteriosclerosis, Generalized DUE TO (c) Generalized Osteoporosis			INTERVAL BETWEEN ONSET AND DEATH 48 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Osteoporosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 18, 1967 to 9.3 , 19 67 , that (I) (we) last saw the deceased alive on 9-3-67 19 67 , and that death occurred at 8:45 A.M. , from causes and on the date stated above.			
22a. SIGNATURE William P. James		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 9/4/67
22c. PHYSICIAN'S NAME (Type) DR. W. P. JAMES		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/ 6/67	23c. NAME OF CEMETERY OR CREMATORY Stallings Cemetery	23d. LOCATION (City or Town) (County) (State) Near Oldtown, Alleg Md.
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR SEP 7 1967	
ADDRESS 230 Balto Ave., Cumberland		25b. REGISTRAR'S SIGNATURE Charles Judge	

11332

CERTIFICATE OF DEATH

ALLEGANY

MARYLAND

ALLEGANY

CLAREMONT, MD.

20 DAYS

CIMBERLAND

JANE CLAREMONT VILLAGE

GENERAL HOSPITAL

EVANS, B. J.

BLANCHE

SEP 10 1900

B-6-23

WHITE

U.S.A.

U.S.A.

U.S.A.

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U.S.A.

U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

11760		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		11773	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WEST VIRGINIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 113 HIGHLAND AVENUE		85-3	
3. NAME OF DECEASED (Type or print) OLIE First Middle Last M. FEASTER		4. DATE OF DEATH Month Day Year SEPTEMBER 7, 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11-18-1888		9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Std. Oil Co.		11. BIRTHPLACE (County & State, or foreign country) MAYSVILLE, W. VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES FEASTER		14. MOTHER'S MAIDEN NAME ANNIE GROVES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular disease 331X DUE TO and thromboses Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cum. & Perry Md.	
20f. (City or town) (County) (State) Cum. & Perry Md.		21. I certify that (I) (this hospital) attended the deceased from 9/2/67 , 19 to 9/7/67 , 19 that (I) (we) first saw the deceased alive on 9/2/67 , 19, and that death occurred at 5:00 A.M. on the date stated above.			
22a. SIGNATURE [Signature]		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/7/67	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS CUMBERLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-9-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Hebron	
23d. LOCATION (City or Town) (County) (State) Petersburg Grant W. Va		24. FUNERAL DIRECTOR Arnold Fun. Hm. Petersburg, W. Va.			
25a. REC'D BY REGISTRAR SEP 18 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

11360

WEST VIRGINIA

ALLEGANY

PETERSBURG

1 WEEK

CUMBERLAND

113 HIGHLAND AVENUE

MEMORIAL HOSPITAL

SEPTEMBER 7, 63

FEASTER

M.

OLIE

78

11-18-1888

WHITE

HALE

USA

WAYSVILLE, W. VA.

RETIRED

ANNIE GROVES

CHARLES FEASTER

MEMORIAL HOSPITAL, CUMBERLAND, MD.

2:00 A.M.

CUMBERLAND, MARYLAND

DR. R. J. WILLIAMS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G392 9/11/67 ph

11761

CERTIFICATE OF DEATH

11774

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 10 MIN.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL, CUMBERLAND, MD.		e. STREET ADDRESS 415 SOUTH ST.	
3. NAME OF DECEASED (Type or print) First ERNEST Middle N. Last FRANZE		4. DATE OF DEATH Month SEPTEMBER Day 2 Year 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1920 10-22-1920
9. AGE (In years lost 46 yrs.)		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND-CUMBERLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DOMINICO FRANZE (Domenico)		14. MOTHER'S MAIDEN NAME KATHERYN BARBERI	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War II		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial infarction DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery hypertensive heart disease (c) 6 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 19 1967 , that (I) (we) lost saw the deceased alive on Sept 19 1967 , and that death occurred at 10:25 P.M. , from causes and on the date stated above.			
22a. SIGNATURE S. G. WEISMAN		22b. DATE SIGNED 3 Sept 1967	
22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 5, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR SEP 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

11001

ALLEGANY

CUMBERLAND, MD.

TO WIA.

CUMBERLAND

MEMORIAL HOSPITAL, CUMBERLAND, MD. 15 SOUTH ST.

ERLEST

FRANKE

SEPTEMBER 2

WHITE

X 10 22 1921

43

MARYLAND

U.S.A.

KATHERY

CLINICAL FRANK

MEMORIAL HOSPITAL, CUMBERLAND, MD.

10:25 P.M.

CUMBERLAND, MD.

2. B. WESTMAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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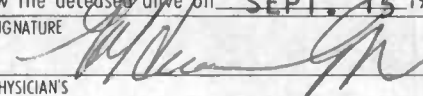
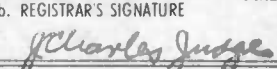
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11762

CERTIFICATE OF DEATH

11775

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10HRS. 25MIN.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 548 NATIONAL HIGHWAY	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle Harrison Last HARDEN		4. DATE OF DEATH Month SEPTEMBER Day 15 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-1897
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager		10b. KIND OF BUSINESS OR INDUSTRY NAT'L JET.CO.	
11. BIRTHPLACE (County & State, or foreign country) HYNDMAN, PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL HARDEN		14. MOTHER'S MAIDEN NAME SARA MILLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 214-07-1527	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) WITH MARKED CORONARY INSUFFICIENCY			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 to SEPT , 19 67 , that (I) (Xe) last saw the deceased alive on SEPT. 15 19 67 , and that death occurred at 5:10 PM from causes on and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 9/18/67	
22c. PHYSICIAN'S NAME (Type) G.O. HIMMELWRIGHT, M.D.		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL (Cremation, Removal, Specify) Burial	23b. DATE THEREOF 9/18/67	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE SEP 20 1967	
		25b. REGISTRAR'S SIGNATURE 	

30

NO. 21, 1904

• 93 • 131 • 148

Office Address:

145

11768

CERTIFICATE OF DEATH

11776

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 19 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat		d. STREET ADDRESS 608 N. 2nd Street	
3. NAME OF DECEASED (Type or print) First Elwood Middle Walter Last Henry		4. DATE OF DEATH Month Sept. Day 29 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1894
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 01 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire Dye House Foreman		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Co. Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Henry		14. MOTHER'S MAIDEN NAME Wilhelmina K. Krug	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-104051	
17. INFORMANT Mrs. Dorothy Henry		Address 608 N. 2nd St. LaVale	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Generalized Atherosclerosis DUE TO (c) Emphysema			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 15, 19 67 to Sept. 29, 19 67 , that (I) (we) last saw the deceased alive on Sept. 28, 19 67 , and that death occurred at 8:30 AM from causes on and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE SIGNED 9/29/67	
22c. PHYSICIAN'S NAME (Type) George M. Simons, M.D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/ 2/67	23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Near Cumberland, Alleg Md
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR OCT 3 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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11708

RECORDS OF BIRTH

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF STATISTICS

DATE OF BIRTH

PLACE OF BIRTH

NAME OF FATHER

NAME OF MOTHER

NAME OF CHILD

SEX OF CHILD

AGE OF CHILD

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

NAME OF DOCTOR

NAME OF NURSE

NAME OF WITNESS

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF CHIEF

NAME OF DEPUTY

NAME OF CLERK

1908

1909

1910

1911

1912

1913

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please retain this certificate. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11764

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2d Film #G392 9/21/67 ph

CERTIFICATE OF DEATH

11777

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/6/1967		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary			d. STREET ADDRESS Union Rescue Mission, Front Street 316 Park St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Allen Middle A. Last Hoover			4. DATE OF DEATH Month September Day 12 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/31/1884	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Celanese Employee.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
13. FATHER'S NAME John Hoover			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			14. MOTHER'S MAIDEN NAME Phoebe Simmons		
16. SOCIAL SECURITY NO. 220-10-4062			17. INFORMANT P.O. Box 599, Cumberland, Md. Allegany County Infirmary records.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Chronic arteriosclerosis (b) A.S. DUE TO Chronic S.H.D. (c) Many years					INTERVAL BETWEEN ONSET AND DEATH 8 days Many years Many years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Stroke Hemiparesis Alcoholism etc.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6/6/1967 , 19__, to 9/12/1967 , 19__, that (I) (we) last saw the deceased alive on 9/11/1967 , 19__, and that death occurred at A. M, from causes and on the date stated above.					
22a. SIGNATURE John A. Topper		at 5:20 A. M. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/12/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/14/67	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland		
24. FUNERAL DIRECTOR H. Lee Silcox			25a. REC'D BY REGISTRAR SEP 15 1967		
25b. REGISTRAR'S SIGNATURE Judge					

11364

Allegany

Allegany

Allegany

Chamberlain

6/6/1937

Chamberlain

Allegany County Jail

Allegany County Jail

Allen

Allen

September 13, 1937

Maria

White

7/31/1937

63

Allegany County Jail

Allegany County Jail

U. S. A.

Allegany County Jail

Allegany County Jail

Allegany County Jail

Allegany County Jail

Allegany County Jail

Allegany County Jail

Allegany County Jail

John A. Kopper, W. D.

Memorial Hospital, Cumberland, Md.

SEP 11 1937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11765

CERTIFICATE OF DEATH

11778

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 411 AVIRETTE AVENUE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOPE ELLEN KELLEY		4. DATE OF DEATH Month SEPTEMBER Day 30 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-5-87
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEXTILE WORKER		10b. KIND OF BUSINESS OR INDUSTRY TEXTILE PLANT	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS KELLEY		14. MOTHER'S MAIDEN NAME JUDY, CLARA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-07-4643	
17. INFORMANT Mrs. Clarence Jones		Address 504 Avirett Ave. Cumb. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary artery disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystic degeneration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-27 , 19 67 , to 9-29 , 19 67 , that (I) (we) last saw the deceased alive on 9-29 , 19 67 , and that death occurred at 4:54 AM , from causes and on the date stated above.			
22a. SIGNATURE Lewis Brings		22b. DATE SIGNED 10-1-67	
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.		22d. ADDRESS 57 GREENE ST., CUMB., MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR OCT 4 1967	
ADDRESS GEORGE FUNERAL HOME 202 GREENE STREET CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Charles Jones	

11703

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

3 DAYS

CUMBERLAND

SACRED HEART HOSPITAL

111 AVIETTE AVENUE

HOSP

E.

KELLEY

SEPTEMBER

30

27

FEMALE WHITE

02-2-27

80

TEXTILE WORKER

TEXTILE

CUMBERLAND, MD.

USA

THOMAS KELLEY

JUDY

HO

214-07-1013 HOSP. RECORD

LEWIS BRIGGS, D.D.

25 GREENE ST., CUMBERLAND, MD. 21202

GEORGE FUNERAL HOME 202 GREENE STREET CUMBERLAND, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11766

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11779

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1 MONTH 2 DAYS c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL -900 SETON DR.		d. STREET ADDRESS 278 E. MAIN STREET	
3. NAME OF DECEASED (Type or print) First Middle Last FRANK PATRICK KELLY		4. DATE OF DEATH Month Day Year SEPTEMBER 19 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-84
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRAIL MAGISTRATE		10b. KIND OF BUSINESS OR INDUSTRY PEOPLES COURT	
11. BIRTHPLACE (County & State, or foreign country) SHAFT, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER KELLY		14. MOTHER'S MAIDEN NAME ANN (BROGAN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-5399	
17. INFORMANT HOSPITAL RECORD		Address 900 SETON DRIVE, CUMBERLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rt. Lung with extension to 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) mediastinal nodes and esophagus DUE TO (c) Uncertain.		INTERVAL BETWEEN ONSET AND DEATH Uncertain.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-17, 1967 , to 9-19, 1967 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 19 M, from causes on and on the date stated above.			
22a. SIGNATURE Calvin Y. Hadidian		22b. DATE SIGNED 9-19-67	
22c. PHYSICIAN'S NAME (Type) CALVIN HADIDIAN, M.D.		22d. ADDRESS WASHINGTON & CUMBERLAND STREETS CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEM.		23d. LOCATION (City or Town) (County) (State) FROSTBURG, ALLEGANY, MD.	
24. FUNERAL DIRECTOR MARLOU M. SOWERS		25a. REC'D BY REGISTRAR SEP 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. HOME, 60 W. MAIN, FROSTBURG	

11760

ALLENBY

MARYLAND

CONSERVATION

PROSTHESIS

SACRED HEART HOSPITAL - 400 SEYMOUR DR. 278 E. MAIN STREET

FRANK

PATRICIA KELLY

SEPTEMBER 19

MALE

WHITE

8-7-84

53

TRAIL STATE

PEOPLES COURT

SHAW, MD.

U.S.A.

PETER KELLY

ARM (PROGAM)

NO

214-02-2399

HOSPITAL RECORD

400 SEYMOUR DRIVE, LUMBERT AND

CALVIN HADRIAN, M.D.

WASHINGTON & CONNELLAND STREETS

CUMBERLAND, MD. 21212

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11767

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11780

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			c. LENGTH OF STAY IN 1b 55 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL				d. STREET ADDRESS 115 BOWERY STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle KENNEDY Last Month SEPT. Day 21, Year 19 67				4. DATE OF DEATH			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 11, 1886	
9. AGE (In years last birthday) 81 YRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ROBERT MOSES			
14. MOTHER'S MAIDEN NAME ANNA TUESDALE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT GEORGE KENNEDY, 107 GEORGE ST., FROSTBURG, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Myocardial Failure INTERVAL BETWEEN ONSET AND DEATH Months DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Chronic Myocarditis " (c) Arteriosclerosis "							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Intertrochanteric Fracture of Right Femur							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home		20c. TIME OF INJURY Month, Day, Year 10:00AM Sept. 19 '67					
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Frostburg, Alleg. Maryland		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED Sept. 21, 1967		23. LOCATION (City or Town) (County) (State) FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 24 '67		23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR SEP 29 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

2

1151



SEP 20 1907

11768

CERTIFICATE OF DEATH

11781

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6WKS, 4DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 01.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 107 PARK STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ADRIAN V. KERNS				4. DATE OF DEATH Month SEPTEMBER Day 28 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-27-1886		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TANNERY WORKER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME THOMAS KERNS			14. MOTHER'S MAIDEN NAME SARA MILBURN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 232-10-2461		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery Disease DUE TO Myocardial Infarction (b) Myocardial Infarction DUE TO Myocardial Infarction (c) Myocardial Infarction							INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept 27, 1967 to Sept 28, 1967 that (I) (we) last saw the deceased alive on Sept 27, 1967 and that death occurred at 4:30 AM at Memorial Hospital and on the date stated above.							
22a. SIGNATURE Dr. Blaine Schindler		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/28/67			
22c. PHYSICIAN'S NAME (Type) DR. BLAINE SCHINDLER		22d. ADDRESS CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/30/67	23c. NAME OF CEMETERY OR CREMATORY Woodrow Cemetery		23d. LOCATION (City or town) (County) (State) Paw Paw Hampshire West Va			
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS Cumberland, Maryland 21502		25a. REC'D BY REGISTRAR Oct 2 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jorg	

CERTIFICATE OF DEATH

1900

ALLEGANY

MARYLAND

CUMBERLAND

CHURCH, HAYS

CUMBERLAND

103 PARK STREET

MEMORIAL HOSPITAL

LEWIS, V. J. SEPTEMBER 20, 1900

ADRIAN

4-27-1886

MALE WHITE

USA VIRGINIA

RETIRED

SARA HILBORN

THOMAS KENNIS

MEMORIAL HOSPITAL, CUMBERLAND, MD

202-1-2000

MD

CUMBERLAND, MARYLAND

DR. BRADY SCHINDLER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11769

CERTIFICATE OF DEATH

11782

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MORGAN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 50 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 75-3	
3. NAME OF DECEASED (Type or print) JOSEPH First H Middle KLINE Last		4. DATE OF DEATH Month SEPTEMBER Day 7 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 89 IF UNDER 1 YEAR: Months 8 Days 19 Hours 67 Min.
11. BIRTHPLACE (County & State, or foreign country) HAMPSHIRE CO. W. VA.		12. CITIZEN OF WHAT COUNTRY? S. A.	
13. FATHER'S NAME JOSEPH KLINE		14. MOTHER'S MAIDEN NAME CATHERINE SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic C.V.D. DUE TO Generalized Arterio Sclerosis at least Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 8 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Month 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) P.T. 67
21. I certify that (I) (this hospital) attended the deceased from 7-19-67 , 19 67 7:35 P.M. , that (I) (we) last saw the deceased alive on 9-7-67 , and that death occurred at 9-8-67 M, from causes and on the date stated above.			
22a. SIGNATURE W. F. Williams		22b. DATE SIGNED 9-8-67	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9/10/67	23c. NAME OF CEMETERY OR CREMATORY CAMP HILL	23d. LOCATION (City or Town) (County) (State) PAW PAW, MORGAN W. VA.
24. FUNERAL DIRECTOR JOHNSON FUNERAL HOMES		25a. REC'D BY REGISTRAR SEP 11 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

11389

STATE OF MICHIGAN

WEST VIRGINIA MORGAN

PAW PAW

80 DAYS

CHUBB AND

MEMORIAL HOSPITAL

WIFE

WIFE

JOSEPH KLINE

CATHERINE KLINE

MEMORIAL HOSPITAL, CHUBB AND

CHUBB AND

W. F. WILLIAMS

SEP 11 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11770

CERTIFICATE OF DEATH

11783

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 6 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE		d. STREET ADDRESS 01/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELMER Middle WILSON Last LASHLEY		4. DATE OF DEATH Month SEPTEMBER Day 25 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-28-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Contractor & Farmer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY PENN.	9. AGE (In years last birthday) 89
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LOUIS LASHLEY		14. MOTHER'S MAIDEN NAME MARTHA JANE IMES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-36-8467	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gas gangrene DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Amputation Mid th. thigh DUE TO (c) for marked vascular degeneration 6 days INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9:20 , 19 67 , to 9:25 , 19 67 that (I) (we) last saw the deceased alive on 9:25 , 19 67 , and that death occurred at 9:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE W. F. Williams M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) W. F. WILLIAMS		22d. ADDRESS CUMBERLAND, MD.	
22b. DATE SIGNED 9-26-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/28/67	
23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery		23d. LOCATION (City or Town) (County) (State) Chaneyville Bedford Pa	
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS Cumberland, Maryland 21502	
25a. REC'D BY REGISTRAR OCT 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

11770

ALLIE ANN

CUMBERLAND

MEMORIAL HOSPITAL

ELDER

MALE WHITE

LOUIS LASHLEY

2-2-1932

NO

MARTIN LANE MES

MEMORIAL HOSPITAL, CUMBERLAND, MD.

CUMBERLAND, MD.

WILLIAMS

SEPTEMBER 22

LASHLEY

ELDER

2-2-1932

BEHN.

FLINTSTONE

DAYS

CUMBERLAND

ALLEGANY

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, STATE OF MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

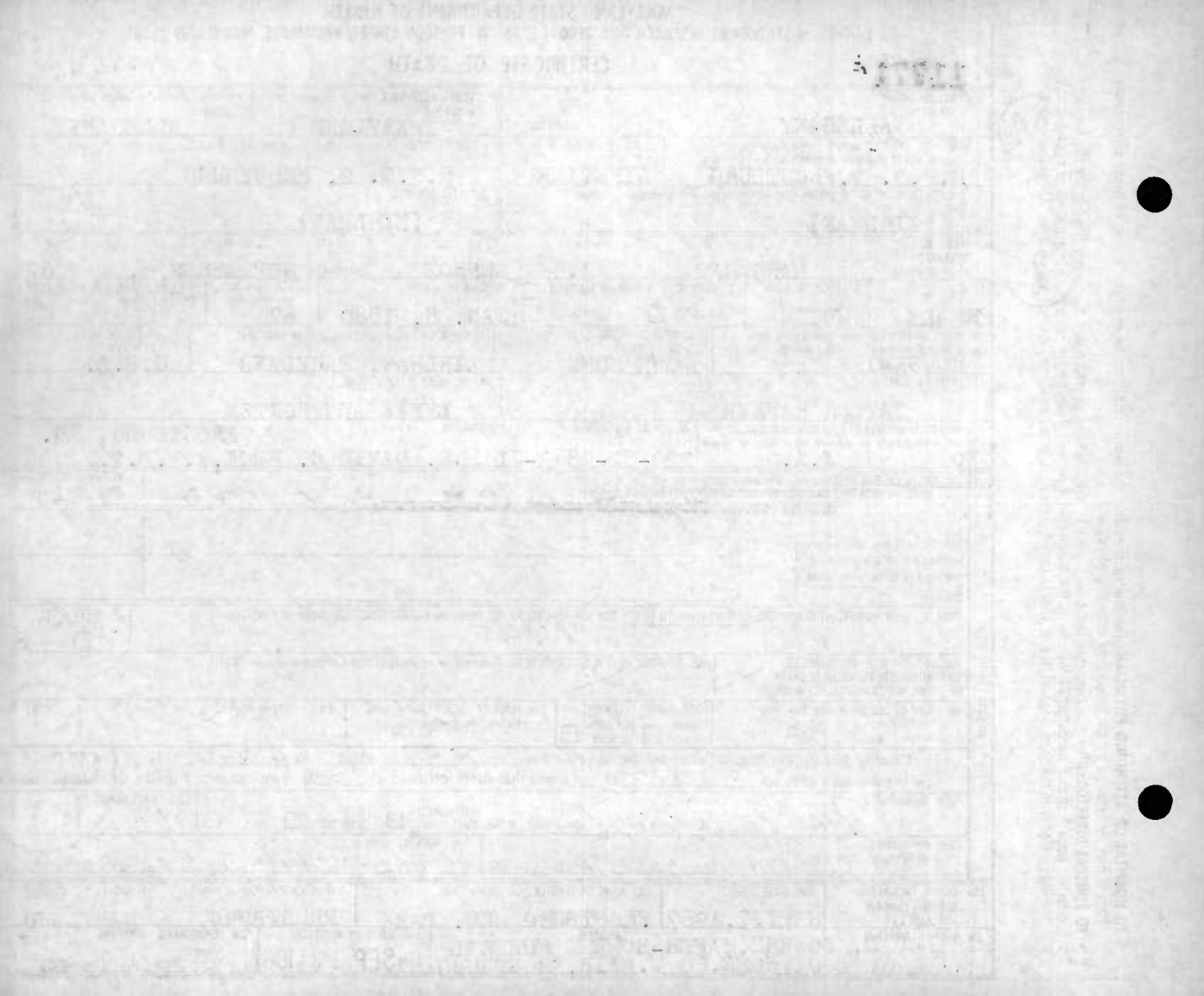
11771

11784

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. 2, FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. 2, FROSTBURG	
c. LENGTH OF STAY IN 1b LIFETIME		d. STREET ADDRESS (ZIHLMAN)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (ZIHLMAN)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle R. Last LENNOX		4. DATE OF DEATH Month SEPTEMBER Day 4 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 8, 1880
9. AGE (In years last birthday) yrs. 87		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) ZIHLMAN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME TAYLOR RANKIN		14. MOTHER'S MAIDEN NAME LYDIA ANN PORTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. N.A.	
17. INFORMANT MRS. DAVID C. BECK, R.F.D. 2,		FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic CVD. DUE TO (b) 443X DUE TO (c) 25 yrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year. Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from DEC. 1960 , to 4 SEPT. 1967 , that (I) (we) last saw the deceased alive on 4 SEPT. 1967 , and that death occurred at 7:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein M.D.		22b. DATE SIGNED 9/4/67	
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.		22d. ADDRESS 48 BROADWAY - FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 7, 1967	
23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MARYLAND	
24. FUNERAL DIRECTOR MARILOU M. SOWERS, HAFFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG		25a. REC'D BY REGISTRAR SEP 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



11772

CERTIFICATE OF DEATH

11785

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN lb 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BARTON
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS MAIN STREET	
3. NAME OF DECEASED (Type or print) MARY C. LOGSDON		4. DATE OF DEATH Month 09 Day 22 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-29-00
9. AGE (In years last birthday) yrs. 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOREKEEPER	
11. BIRTHPLACE (County & State, or foreign country) ALLEGANY CTY., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MARTIN BARRY		14. MOTHER'S MAIDEN NAME ROSS Matilda Ross	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-09-7820	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 330 X Subarachnoid hemorrhage DUE TO (b) Ruptured aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <i>Clarence J. Vincent</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. CLARENCE J. VINCENT		22d. ADDRESS 126 N. SMALLWOOD ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/25/67	23c. NAME OF CEMETERY OR CREMATORY St. Marys	23d. LOCATION (City or Town) (County) (State) Lonaconing Md.
24. FUNERAL DIRECTOR E. S. BOAL <i>E. S. Boal</i>		25a. REC'D BY REGISTRAR DATE SEP 26 1967	
25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

11378

CLINICAL RECORD

ALLERANY

MARYLAND

ALLERANY

BARTON

2 DAYS

CUMBERLAND, MD.

MAIN STREET

SACRED HEART HOSPITAL

03 22 67

LONDON

C.

MARY

67

02-29-00

X

WHITE

FEMALE

U.S.A.

ALLERANY CTY, MD.

STOREKEEPER

Pass

JOHN MARTIN DORRY

218-03-7020 HOSPITAL RECORD

10

20 N. 24 LINDEN ST. CUMBERLAND, MD.

DR. CLARENCE J. WINCENT

WESTERNPORT, MD.

2. 2. 201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

11778

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11786

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 45 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital			d. STREET ADDRESS 34 South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Peter Middle M. Last Malachowski			4. DATE OF DEATH Month Sept. Day 19 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1898		9. AGE (In years last birthday) yrs. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilermaker Railroad		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Malachowski			14. MOTHER'S MAIDEN NAME Jesse Woislaw		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Address Wife Mrs. Rose Malachowski, Cumberland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 CORONARY OCCLUSION DUE TO (b) CORONARY SCLEROSIS DUE TO (c) ---					INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 19, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			25a. REC'D BY REGISTRAR DATE SEP 21 1967	25b. REGISTRAR'S SIGNATURE f Charles Judge	

11176

Algeria, Algeria, Algeria

Cameroon, Cameroon, Cameroon

Central African Republic, Central African Republic, Central African Republic

Chad, Chad, Chad

Cote d'Ivoire, Cote d'Ivoire, Cote d'Ivoire

Guinea, Guinea, Guinea

Guinea-Bissau, Guinea-Bissau, Guinea-Bissau

Senegal, Senegal, Senegal

Sierra Leone, Sierra Leone, Sierra Leone

Sierra Leone, Sierra Leone, Sierra Leone

Sierra Leone

Sierra Leone, Sierra Leone, Sierra Leone

Sierra Leone, Sierra Leone, Sierra Leone

Sierra Leone, Sierra Leone, Sierra Leone

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
11774 11787									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. VIRGINIA COUNTY Bedford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 68 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chaneyville, Rural			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS ---				
3. NAME OF DECEASED (Type or print) First ESTIN Middle --- Last MALLOW					4. DATE OF DEATH Month SEPT. Day 11 Year 67				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-1-94		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm owner		11. BIRTHPLACE (County & State, or foreign country) W. VIRGINIA Pendleton			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GRANT MALLOW					14. MOTHER'S MAIDEN NAME IDA DOLLY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown			16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL			Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widespread Metastatic Carcinoma DUE TO (b) Prostatic Adenocarcinoma DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH 7 Yrs. Yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7/5/67 to 9/11/67 , that (I) (we) last saw the deceased alive on 9/11/67 , and that death occurred at 8:35A M, from causes and on the date stated above.									
22a. SIGNATURE Walter N. Himmler					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 9/12/67	
22c. PHYSICIAN'S NAME (Type) DR. WALTER HIMMLER					22d. ADDRESS CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/13/67		23c. NAME OF CEMETERY OR CREMATORY Mallow Family Cemetery			23d. LOCATION (City or Town) (County) (State) Nr. Riverton, Pendleton, W. Va.		
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.					25a. REC'D BY REGISTRAR DATE SEP 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

11774

CERTIFICATE OF DEATH

ALL EMBRY

CHURCHLAND

MEMORIAL HOSPITAL

SECTION

WHITE

WIFE

V. VIRGINIA

CHURCHLAND

CHURCHLAND

GRANT HALL

IDA BOLL

CHURCHLAND, VA.

CHURCHLAND

DR. WALTER MILLER

CHURCHLAND, VA.

SEP 1941

CHURCHLAND, VA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11775

11788

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN Tb 5 MO. 11 DYS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		01.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SYLVAN RETREAT CUMBERLAND, MD.		d. STREET ADDRESS 11810 BOX 599 216 Fulton St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BELLE First MARKS. Last		4. DATE OF DEATH Month 9 Day I Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/12/1887
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 9 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) LONA CONING, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Higgins		14. MOTHER'S MAIDEN NAME Mary (Douglas)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Kenneth Grimes Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, Acute DUE TO A.S. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chr Hyp. A.S.H.D. DUE TO Chr Hyp. A.S.H.D. (c) Chr Hyp. A.S.H.D.		INTERVAL BETWEEN ONSET AND DEATH 35 months many years many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) C.V.A. 8/21/67 Cardiomegaly		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr 13 , 1967, to Sep 1 , 1967, that (I) (we) lost the deceased alive on SEP 1 1967, and that death occurred at 4:52 P.M. from causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED SEP 2, 1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper		22d. ADDRESS Memorial Hospital Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR William G. Kight		25a. REC'D BY REGISTRAR SEP 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

2551

11776

CERTIFICATE OF DEATH

11789

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND YEARS		c. LENGTH OF STAY IN 1b CUMBERLAND RURAL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARL First Middle Last		4. DATE OF DEATH SEPTEMBER 8, 1967 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-1902
9. AGE (In years lost birthday yrs.) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PLUMBER	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM A. MARTIN		14. MOTHER'S MAIDEN NAME LILLIAN RIZER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-09-3405	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Carcinomatosis Generalized DUE TO (b) Adeno-Carcinoma Lung stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH Not Known	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August, 1967 to 8 Sept., 1967 that (I) (we) last saw the deceased alive on 8 Sept 67 19 67 , and that death occurred at 3:25 AM , Arms and on the date stated above.			
22a. SIGNATURE Dr. Whitworth		22b. DATE SIGNED Sept 8, 1967	
22c. PHYSICIAN'S NAME (Type) DR. WHITWORTH		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Near Cumberland, Alleg Md
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11776

ALLEGANY

ALLEGANY

ALLEGANY

CUMBERLAND

CUMBERLAND

REYNOLDS

REYNOLDS

CHIEF

CHIEF

WHITE

WHITE

RETIRED

RETIRED

WILLIAM A. WATSON

WILLIAM A. WATSON

REYNOLDS

CUMBERLAND

REYNOLDS

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11777

11790

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 50 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 630 HILL TOP DRIVE	
3. NAME OF DECEASED (Type or print) HELEN V. MATHEWS		4. DATE OF DEATH Month SEPT. Day 26 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 31, 1881
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 26 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM H. CHAPLINE		14. MOTHER'S MAIDEN NAME IDA M. COOKUS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217 48 2305	
17. INFORMANT MRS. ELIZABETH KONZAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) --			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.	
22. DATE SIGNED SEPT. 26, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF SEPT. 28, 1967	23c. NAME OF CEMETERY OR CREMATORY ELMWOOD CEMETERY	23d. LOCATION (City or Town) (County) (State) SHEPHERDSTOWN, W. VA.
24. FUNERAL DIRECTOR BYRON KIGHT ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR OCT 2 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

11776

Department of Agriculture
Washington, D.C.

X X

Comptroller, No. 1

DOT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11778

CERTIFICATE OF DEATH

11791

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 HRS. 15 MIN.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BUFFALO MILLS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS RT. 1 BOX 73		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First JOHN Middle RAY Last MAYS		4. DATE OF DEATH Month SEPTEMBER Day 3 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-27-1891		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE MAYS				14. MOTHER'S MAIDEN NAME ANNIE SUDER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 218-34-4442		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/3/67 , 19 67 , at 7:30 P.M. , that (I) (we) last saw the deceased alive on 9/3 , 19 67 , and that death occurred at 7:30 P.M. , from causes and on the date stated above.							
22a. SIGNATURE A. C. Dross		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 4, 67			
22c. PHYSICIAN'S NAME (Type) DR. I. C. DROSS		22d. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Madley Cemetery		23d. LOCATION (City or Town) (County) (State) Hyndman RD #1 Bedford Pa	
24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa		ADDRESS		25a. REC'D BY REGISTRAR OATE SEP 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

11178

ALLIANCE

CHURCHMAN

MEMORIAL HOSPITAL

PENNSYLVANIA

BUFFALO WILLS

RT. 1 BOX 73

SEPTICEMER

WAYS

RAY

JACK

JOHN

4-27-1891

WHITE

MALE

U. S. A.

PENNSYLVANIA

CHURCHMAN

CHURCHMAN

ANNIE SUDD

GEORGE WAYS

NO

CHURCHMAN MEMORIAL HOSPITAL, CHURCHMAN, W.D.

5:30 P.M.

CHURCHMAN, W.D.

DR. I. C. CROSS

CHURCHMAN

CHURCHMAN

CHURCHMAN

CHURCHMAN

CHURCHMAN, W.D.

11778

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11792

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 40 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hospital				d. STREET ADDRESS 120 West First St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edgar S. Mc Donald				4. DATE OF DEATH Month Sept. Day 6 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1917		9. AGE (In years last birthday) yrs. 49		10. UNDER 1 YEAR Months 4 Days 1 Hours 1 Min. 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spinner			10b. KIND OF BUSINESS OR INDUSTRY Textile		11. BIRTHPLACE (State or foreign country) Romney, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Virgil Mc Donald				14. MOTHER'S MAIDEN NAME Blanche Peer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War II		16. SOCIAL SECURITY NO. 217-10-4389		17. INFORMANT Address Mrs. Esther Mc Donald, Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH SUDDEN							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 6, 1967 Cumberland, Md. Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE SEP 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

11370

11780

CERTIFICATE OF DEATH

11793

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL N		d. STREET ADDRESS 512 MARYLAND AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last GUY EDWARD MC KENZIE		4. DATE OF DEATH Month Day Year 9 20 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-23-92
9. AGE (In years lost birthday) yrs. 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTOMER	
11. BIRTHPLACE (County & State, or foreign country) KEYSER, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES MC KENZIE		14. MOTHER'S MAIDEN NAME MARGARET ANN FLEEK	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-10-8001	
17. INFORMANT HOSPITAL RECORD - 200 SETON DR., CUMB., MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Woman</u> DUE TO (b) <u>Chronic Pyelonephritis</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-17</u> , 19 <u>67</u> , to <u>9-20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-20</u> , 19 <u>67</u> , and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W.C. Spiggle</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WAYNE C. SPIGGLE, M.D.		22d. ADDRESS 126 N. SMALLWOOD ST., CUMB., MD 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9/23/67	23c. NAME OF CEMETERY OR CREMATORY Potomac Valley Gardens	23d. LOCATION (City or Town) (County) (State) Keyser W. Va.
24. FUNERAL DIRECTOR <u>E. J. Breal</u>		25a. REC'D BY REGISTRAR OATE SEP 26 1967	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11580

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MARYLAND

ALLEGANY

CUMBERLAND

3 DAYS

WESTERNPORT

SACRED HEART HOSPITAL X

212 MARYLAND AVENUE

GUY

EDWARD

MC KEZIE

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WHITE

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CUSTODIAN

WARD 1

KEYSER, WEST VIRGINIA

MARGARET W FLECK

CHARLES MC KEZIE

212-10-0001

AD

HOSPITAL RECORD - 200 SETON DR., CAMP, IN

WAYNE C. SPAGLE, I.D.

12211, SMALLWOOD ST., CAMP, IN 21202

11781

CERTIFICATE OF DEATH

11794

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 90 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		01.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Castle Street				d. STREET ADDRESS Castle Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle S. Last MILFORD				4. DATE OF DEATH Month 9/10/1967 Day 19 Year 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16th. 1877	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 9 Days 10 Hours 19 Min.		IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Seggie				14. MOTHER'S MAIDEN NAME Elizabeth Lindsey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Henry Milford Lonaconing, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia (SON) DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Generalized Atherosclerosis (b) Coronary Insufficiency (c) Generalized Atherosclerosis years							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular insufficiency							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 to Sept 10, 1967 , that (I) (we) last saw the deceased alive on Sept. 7, 1967 , and that death occurred at 7 A.M. , from causes and on the date stated above.							
22a. SIGNATURE L.R. Miles, Jr.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-11-67	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.				22d. ADDRESS LONA CONING MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/1967		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR George Eichhorn				ADDRESS Lonaconing, Md.		25a. REC'D BY REGISTRAR SEP 13 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11381

EXHIBIT OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11782

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11795

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital D. O. A.			d. STREET ADDRESS 29 Ridgeway Terrace		
3. NAME OF DECEASED (Type or print) William Miller			4. DATE OF DEATH Month September Day 6 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1914		9. AGE (In years lost birthday) 52 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing & Heating		10b. KIND OF BUSINESS OR INDUSTRY Engineer		11. BIRTHPLACE (State or foreign country) Cumberland Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Louis Miller		
14. MOTHER'S MAIDEN NAME Marie Parks			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW1		
16. SOCIAL SECURITY NO. 212-18-1356			17. INFORMANT Marie Miller 29 Ridgeway Terrace		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		September 6, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City or Town) (County) (State) Cumberland Allegany MD.		24. FUNERAL DIRECTOR Louis Stein Inc. Cumberland Md		25a. REGISTRAR'S SIGNATURE Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE SEP 11 1967			

11384

Allegany Maryland

Chesapeake Maryland

2200 1st Hospital A. O. A. 22 Highway Terrace

Miller September 65

White 22 12, 1911

Living 8 Heating Cumberland Maryland

Louis Miller 22 12, 1911

Yes 22 12, 1911 22 Highway Terrace

Coronary Coronary

Coronary Coronary

X X X

X

X September 6, 1907
Cumberland Maryland

RESEARCH ANTICANCER, N.D.

Sept. 9, 1907 Rose Hill Cemetery

SEP 11 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11783

CERTIFICATE OF DEATH

11796

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/5/1967	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 676 Greene Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Belle Morris		4. DATE OF DEATH Month September Day 8 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1880
9. AGE (In years last birthday) yrs. 86		IF UNDER 1 YEAR Months 8 Days 13 Hours 15 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Frosburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Smouse		14. MOTHER'S MAIDEN NAME Mary Hitchins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-52-9275T	
17. INFORMANT P.O. Box 599, Cumberland, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Head of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c) Gen. Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/5/1967 , 19__, to 9/8/67 , 19__, that (I) (we) last saw the deceased alive on 9/7/1967 , 19__, and that death occurred at P. M. , from causes and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE SIGNED 9/8/1967	
22c. PHYSICIAN'S NAME (Type) George M. Simons		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/11/67	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md	
24. FUNERAL DIRECTOR John J. Hefer, Jr.		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 230 Balto Ave., Cumberland Md	

11782

STATE OF TEXAS

County of ...

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/64

11784

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11797

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 167 WASHINGTON STREET	
3. NAME OF DECEASED (Type or print) First PAUL Middle SILVER Last MOULDEN		4. DATE OF DEATH Month SEPTEMBER Day 4 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 5, 1921
9. AGE (In years lost birthday) yrs. 46		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work, if not working, give last occupation) FOREMAN MINSTER-ROUNDHOUSE		10b. KIND OF BUSINESS OR INDUSTRY CHURCH-RAILROAD	
11. BIRTHPLACE (State or foreign country) RIDGEWAY, WEST VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY MOULDEN		14. MOTHER'S MAIDEN NAME DELLA MORGAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) YES		16. SOCIAL SECURITY NO. 214-09-9448	
17. INFORMANT MRS. PAUL S. MOULDEN		18. FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 4201 (b) Coronary Sclerosis DUE TO ----- (c) -----		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 7, 1967	
23c. NAME OF CEMETERY OR CREMATORY SUNSET MEM. PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MARYLAND	
24. FUNERAL DIRECTOR MARILOU M. SOWERS		25a. REC'D BY REGISTRAR SEP 13 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S ADDRESS HOME, 60W. MAIN, FROSTBURG	

11734

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PROPERTY OF THE
UNITED STATES GOVERNMENT

RECEIVED
JAN 11 1967
COMMUNICATIONS SECTION
U.S. AIR FORCE

RECEIVED
JAN 11 1967
COMMUNICATIONS SECTION
U.S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the funeral papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11785

CERTIFICATE OF DEATH

11798

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 10 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		d. STREET ADDRESS 1314 VIRGINIA AVE.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLA First Middle Last W. NINES		4. DATE OF DEATH Month Day Year 09 28 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-91
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA Fork		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN WHITE		14. MOTHER'S MAIDEN NAME Frances WOLFORD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-14-5733	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Partial obstruction - carcinoma of liver DUE TO (b) Heart Failure + Renal Failure DUE TO (c) Arteriosclerosis Heart Disease Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 months 5 months 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Megacolon, severe, cause unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 , to 28 Sept, 1967 , that (I) (we) last saw the deceased alive on 28 Sept 1967 , and that death occurred at 3:45 PM , from causes and on the date stated above.			
22a. SIGNATURE S. G. Weisman		22b. DATE SIGNED 29 Sept 1967	
22c. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany	
24. FUNERAL DIRECTOR SCARPELLI FUNERAL HOME, CUMBERLAND, MD.		25a. REC'D BY REGISTRAR OCT 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11383

ALLIED

CHICAGO

2000 WEST HOSPITAL

ELVA

WHITE

WHITE

JOHN WHITE

10-14-23

HOSPITAL RECORD

10 DAYS

CHICAGO

1014 WEST HOSPITAL

ELVA

WHITE

WHITE

JOHN WHITE

09

75

75

75

75

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75

DR. J. C. WEISMAN

TO GREENE ST., CHICAGO, ILL.

GREENE ST. CHICAGO, ILL.

OCT 2 1923

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11799

11786

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 40 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA MEMORIAL HOSPITAL				d. STREET ADDRESS 913 FREDERICK STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JESSIE M. O'NEAL				4. DATE OF DEATH Month SEPT. Day 11 Year 19 67				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 1, 1902		
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months 0 Days 1		11. IF UNDER 24 HRS. Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BOALSBURG, PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES KLINGLER				14. MOTHER'S MAIDEN NAME EMMA WOODS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT CLOYD O'NEAL CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CORONARY SCLEROSIS (c) SODDEN							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.				22. DATE SIGNED 9/11/67				
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 14, 1967		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.		
24. FUNERAL DIRECTOR BYRON KIGHT				25a. REC'D BY REGISTRAR SEP 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

11389



STATE

11389

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11787		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		11800	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VA. b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 3 1/2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY 26753	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL-900 SETON DRIVE		d. STREET ADDRESS 60 KNOBLEY ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First COLUMBUS Middle JACKSON Last PHILLIPS		4. DATE OF DEATH Month SEPTEMBER Day 29 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-82	9. AGE (In years birthday) yrs. 85	IF UNDER 29 Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life) JUSTICE OF PEACE		10b. KIND OF BUSINESS OR INDUSTRY Law Enforcement Agency		11. BIRTHPLACE (County & State, or foreign country) TUCKER COUNTY, WEST VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ABRAHAM PHILLIPS			
14. MOTHER'S MAIDEN NAME MARGARET RAMSEY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. 234-12-4074		17. INFORMANT PTS. HOSPITAL CHART Address SACRED HEART HOSP.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 4201 (b) Atherosclerosis of coronary arteries 10 years DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral pulmonary infarction					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 9-25-67 , 19__, to 9-29-67 , 19__, that (I) (we) last saw the deceased alive on 9-29-67 , 19__, and that death occurred at 10:55 AM causes and on the date stated above.					
22a. SIGNATURE F. Miltenberger		22b. DATE SIGNED 10-2-67		22c. PHYSICIAN'S NAME (Type) F. MILTENBERGER, M.D.	
22d. ADDRESS 122 SOUTH CENTRE ST. CUMB., MD.		22e. ADDRESS 122 SOUTH CENTRE ST. CUMB., MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/2/67	23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		23d. LOCATION (City or Town) (County) (State) Elkins, Randolph, W. Va.	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 4 1967		25b. REGISTRAR'S SIGNATURE P. Charles Judge	

1178

ALLEGANY

COUNTY

3 1/2 DAYS

RIDGELY

2-22

WEST VA.

MINERAL

SACRED HEART HOSPITAL-300 SECON DRIVE

CO. COLEBY ST.

COLLINS

150 W

PHILLIPS

SEPTEMBER 23

27

MALE

WHITE

X

1-20-24

23

JUSTICE OF PEACE

WATER COURT, WEST VA.

USA

ARRIVAL PHILLIPS

NO

23-12-1074

PTS. HOSPITAL CLINT

SACRED HEART HOSP.

8-28-17

7-22-17

10:22 AM

8-22-17

10-2-17

F. HILTBORGER, M.D.

122 SOUTH CENTRE ST. CLINT, MD.

21202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11780

CERTIFICATE OF DEATH

11801

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VIRGINIA b. COUNTY KEYSER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 2 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 41 S. MAIN STREET	
3. NAME OF DECEASED (Type or print) ROBERT First PAUL Middle REID Last		4. DATE OF DEATH Month SEPTEMBER Day 3 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-1899
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Chief		10b. KIND OF BUSINESS OR INDUSTRY Fire Dept	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROBERT REID		14. MOTHER'S MAIDEN NAME MARY BAKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-30-1269	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA Sigmoid Colon with DUE TO 1533 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) advanced metastasis of liver, Apr 1967 DUE TO (c) and liver failure INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 24, 19 67 to Sep 3, 19 67 , that (I) (we) last saw the deceased alive on Sep 2, 19 67 , and that death occurred at 2:00A.M. causes and on the date stated above			
22a. SIGNATURE Wayne M Fawcett		22b. DATE SIGNED Sep 3, 67	
22c. PHYSICIAN'S NAME (Type) DR. FAW		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/6/67	23c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR SEP 6 1967	
Cumberland, Maryland 21502		25b. REGISTRAR'S SIGNATURE Charles Judge	

11782

COUNT OF DEATH

ALLEGY

CUMBERLAND 2 WEEKS

GENERAL HOSPITAL

ROBERT

WHITE

ROBERT

ROBERT

GENERAL HOSPITAL, CUMBERLAND, MD.

CUMBERLAND, MARYLAND

SEP 3 1900

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

11789

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11802

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage	
c. LENGTH OF STAY IN 1b 5 days		d. STREET ADDRESS Route #1 Mt. Savage	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Retzer		4. DATE OF DEATH Month Sept. Day 30 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886 Nov. 15, 1886
9. AGE (In years lost birthday) yrs. 80		10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY B&O Railroad	
11. BIRTHPLACE (State or foreign country) Clearfield, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Retzer		14. MOTHER'S MAIDEN NAME Barbara Ellen Hawk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ella Retzer		Address Rt. #1 Mt. Savage, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO (b) Arteriosclerotic cardiovascular disease, DUE TO Cor Pulmonale; Silicosis; Emphysema (c) Fracture of left Hip.			INTERVAL BETWEEN ONSET AND DEATH 3 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left Hip.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:00 Sept. 26 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Mt. Savage, Alleg. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelis		22. DATE SIGNED September 30, 1967	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF Oct. 3, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery	23d. LOCATION (City or Town) (County) (State) Mt. Savage Allegany Md.
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR OCT 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11-11-1918

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11790

CERTIFICATE OF DEATH

11803

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 3 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat		d. STREET ADDRESS 300 Bedford Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Estella Middle Hester Last Robertson		4. DATE OF DEATH Month Sept. Day 12 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/77
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Midland, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Isaac Stevenson	
14. MOTHER'S MAIDEN NAME Mary Martz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Howard E. Robertson Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Chr. A.S.H.D. DUE TO (c) Squid A.S. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 3 days many years many years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral A.S. with Psychosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 15, 19 67 , to Sept. 12, 19 67 , that (I) (we) last saw the deceased alive on Sept. 11, 19 67 , and that death occurred at 4 A.M. , from causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED SEP 13-1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M.D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/15/1967	23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg A. Md	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR SEP 15 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Lonaconing, Md.	

CERTIFICATE OF MARRIAGE

Myself
and my
husband

James
and
Mary

Witnessed by

John
Doe

1899

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11791

11804

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBARLAND		c. LENGTH OF STAY IN 1b 1WK-1DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 447 BALTIMORE AVE.	
3. NAME OF DECEASED (Type or print) MINTA R. ROBERTSON		4. DATE OF DEATH Month 14 Day 19 Year 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-1911 9. AGE (In years lost birthday) 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL NURSE		11. BIRTHPLACE (County & State, or foreign country) BEDFORD CO, PENNA.	
13. FATHER'S NAME WILLIAM ROBERTS		14. MOTHER'S MAIDEN NAME ELIZA BROWN Bowman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-20-5950	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Parotid DUE TO (b) Carcinomatosis DUE TO (c) Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 19 65 , to Sept 14 , 19 67 , that (I) (we) last saw the deceased alive on Sept 14 , 19 67 , and that death occurred at 11:20 P.M. on Sept 14 , 19 67 , at 447 Baltimore Ave. and on the date stated above.			
22a. SIGNATURE Clayton Durrett		22b. DATE SIGNED 9/16/67	
22c. PHYSICIAN'S NAME (Type) DR. DURRETT		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-17-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Chaneysville Bedford Pa.
24. FUNERAL DIRECTOR H. Lee Silcox		25. REC'D BY REGISTRAR SEP 18 1967	
25b. REGISTRAR'S SIGNATURE H. Lee Silcox		26. ADDRESS 404 Decatur St, Cumb. Md.	

11791

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

TWO-DAY

CUMBERLAND

447 BALTIMORE AVE.

MEMORIAL HOSPITAL

WINTA

R. ROBERTSON

SEPTEMBER 14, 1945

FEMALE WHITE

ELIZABETH

BEERD CO, PENNA.

PRACTICAL NURSE

WILLIAM ROBERTS

ELIZABETH

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. GURRETT

CUMBERLAND, MARYLAND

SEP 17 1945

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11792

11805

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u> 011	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. O. A. Memorial Hosp.</u>		d. STREET ADDRESS <u>121 N. Allegany St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Jule</u> Last <u>Rolley</u>		4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 29, 1886</u>
9. AGE (In years lost birthday) yrs. <u>80</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Tire Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Frenchville, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Francis Rolley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Berthot</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>Yes, W. W. # 1</u>		16. SOCIAL SECURITY NO. <u>214-07-0393</u>	
17. INFORMANT <u>Mrs. Goldie L. Rolley</u>		Address <u>Cumb. Md. 121 N. Allegany St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
<u>Burial</u>		<u>9/11/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	
25a. REC'D BY REGISTRAR DATE <u>SEP 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

9/8/67

22. DATE SIGNED

Rt. # 9

Cumberland, Md.

1172

RECEIVED

COMMUNICATIONS

U. S. A. Foreign Mail

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1910

RECEIVED

Nov. 29, 1955

1910

RECEIVED

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RECEIVED

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RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11798

Item #2d Film #G392 9/19/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11806

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 65 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital			d. STREET ADDRESS Furnace St. Extended		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Thomas Patrick Rooney			4. DATE OF DEATH Month Sept. Day 13 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1878		9. AGE (In years last birthday) yrs. 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) West Moreland, Pa.	
13. FATHER'S NAME Patrick Rooney			14. MOTHER'S MAIDEN NAME Anna King		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Niece Mrs. Robert Blanchard, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: 4221 IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Disease					INTERVAL BETWEEN ONSET AND DEATH Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture left femur and humerus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at county home			
20c. TIME OF INJURY Month, Day, Year 10:00 a.m. Sept. 9 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) County Home		20f. (City or town) (County) (State) Cumberland, Alleg., Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: XXXXXX Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D.		22. DATE SIGNED 9-13-1967	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Rt. 9 Cumberland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 14, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE SEP 15 1967	
				25b. REGISTRAR'S SIGNATURE [Signature]	

3021

Dec. 18, 1878

3.

501-116

U. S. GOVERNMENT PRINTING OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

11794		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		11807	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 25 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS ROSS ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOHN E ROSS			4. DATE OF DEATH Month SEPTEMBER Day 2 Year 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-07		9. AGE (In years or birthday) yrs. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WESTERNPORT, MD.	
13. FATHER'S NAME WILLIAM M. ROSS			12. CITIZEN OF WHAT COUNTRY U.S. A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-09-2416		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 227X Mesothelioma - Pleural. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 1966 , 19 11:25 P.M. Sep 2 , that (I) (we) last saw the deceased alive on Sept 2 19 67 , and that death occurred at 11:25 P.M. Sep 2 , from causes and on the date stated above.					
22a. SIGNATURE DR. G. OVERTON HIMMELWRIGHT		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/4/67	
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT		22d. ADDRESS CUMBERLAND, MD.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/6/67	23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City or Town) Westernport	(County) (State) MD.
24. FUNERAL DIRECTOR E. J. Boral			ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE SEP 8 1967
					25b. REGISTRAR'S SIGNATURE Charles Judge

11304

STATE OF NEW YORK

ALLEGANY

WESTERN

WESTERN

52 DAYS

CORNER

GENERAL HOSPITAL

ROSS ST.

2002

3

ONE

SEPTEMBER 2

WILLIAM

3-20-04

WESTERN, MO.

U. S. A.

ROBERTSON DRINK

WILLIAM M. ROSS

GENERAL HOSPITAL, CORNER, MO.

DR. J. H. HINCHERLY, CORNER, MO.

1

11795

CERTIFICATE OF DEATH

11808

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			c. LENGTH OF STAY IN lb 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL				d. STREET ADDRESS 206 E. MAIN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ROBERT Middle G. Last RUGE				4. DATE OF DEATH Month SEPTEMBER Day 16 Year 1967				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 14, 1901		
				9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 16 Days 19 Hours 67 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) RET. STOCKROOM CLERK			10b. KIND OF BUSINESS OR INDUSTRY HERCULES POWDER		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT J. RUGE				14. MOTHER'S MAIDEN NAME FRANCES SCHREIBER				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO. 214-05-9642A		17. INFORMANT MISS ELIZABETH RUGE, FROSTBURG, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure DUE TO (b) Cor pulmonale DUE TO (c) 2 weeks							INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept. 6, 1967 , to Sept 16, 1967 , that (I) (we) last saw the deceased alive on 8/15/1967 , and that death occurred at 3:20 A.M. , from causes and on the date stated above.								
22a. SIGNATURE G. Paige Strong				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept 16, 1967		
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG				22d. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 18 '67		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.		
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.				25a. REC'D BY REGISTRAR DATE SEP 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11703

STATE OF DEATH

Carbonyl sulfide
acute myocardial failure

A. P. Strong
Sept 10, 1969

Sept 10, 1969

Sept 10, 1969

1
FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11796

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11809

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN b LIFETIME d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 149 MT. PLEASANT STREET		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG d. STREET ADDRESS 149 MT. PLEASANT ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH CATHERINE SKIDMORE		4. DATE OF DEATH Month Day Year SEPT. 6, 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 15, 1886
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) FROSTBURG, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KARL RUPP		14. MOTHER'S MAIDEN NAME ELIZABETH NICKLAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO N.A.		16. SOCIAL SECURITY NO. 216-46-9888	
17. INFORMANT MRS. LEO BARRY, 149 MT. PLEASANT ST.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS (c) SUDDEN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 9, 1967	
22c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		22d. LOCATION (City, town, or country) (State) FROSTBURG MARYLAND	
23. FUNERAL DIRECTOR MARILOU M. SOWERS		24a. REC'D BY REGISTRAR SEP 13 1967	
24b. REGISTRAR'S SIGNATURE Charles Judge		24c. ADDRESS (Street, city, town, or country) Cumberland, Md.	

11298

Revised Edition

Revised Edition, 1955

SEP 13 1955

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11797

CERTIFICATE OF DEATH

11810

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle B. Last SMITH		4. DATE OF DEATH Month 9/6/1967 Day 19 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/16/1895
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Bradey	
14. MOTHER'S MAIDEN NAME Anna Moran		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Edward Smith Midland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial ischemia (Husband) DUE TO (b) Generalized advanced Arteriosclerosis DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 2, 1967 , to Sept. 6, 1967 , that (II) (we) last saw the deceased alive on Sept 5, 1967 , and that death occurred at 2 a.m. from causes and on the date stated above.			
22a. SIGNATURE L.R. MILES, JR. M.D.		22b. DATE SIGNED 9.7.67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS LONA CONING MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/9/1967	23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery	23d. LOCATION (City or Town) (County) (State) Frostburg, Md.
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11798

CERTIFICATE OF DEATH

117811

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 703 FREDERICK ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NELL DREYER SMITH		4. DATE OF DEATH Month SEPTEMBER Day 6 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-1891
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER (Retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD. (ALLEGANY)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE DREYER		14. MOTHER'S MAIDEN NAME ELIZABETH (KAISER) DREYER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-8913	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2043 IMMEDIATE CAUSE (a) Subacute Myelogenous Leukemia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH one year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nor While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1, 1966 , to Aug 6, 1967 , that (I) (we) last saw the deceased alive on Aug 6 1967 , and that death occurred at 8 AM , from causes and on the date stated above.			
22a. SIGNATURE W Spiggle		22b. DATE SIGNED Aug 6 '67	
22c. PHYSICIAN'S NAME (Type) WAYNE SPIGGLE, M.D.		22d. ADDRESS 126 N. SMALLWOOD ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/8/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR SEP 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11332

ALLEGANY

HARYLAND

ALLEGANY

CUMBERLAND

11 DAYS

CUMBERLAND

SACRED HEART HOSPITAL

703 FREDERICK ST.

WELL

DRYER

SMITH

REMALE WHITE

X

A-21-A-2

76

TEACHER (WALSH)

(WALSH)

CUMBERLAND, (ALLEGANY) U. S. A.

GEORGE DRYER

ELIZABETH (WALSH) DRYER

220-10-913 HOSPITAL RECORDS

NO

Handwritten signature

WHITE SPRING, N. D.

22 N. SHILLING ST. THUNDERBOLT, N. D.

SILCOX FUNERAL HOME

104 DECATUR ST.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11799

CERTIFICATE OF DEATH

11812

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS R.F.D. FROSTBURG	
3. NAME OF DECEASED (Type or print) ERVIN CHARLES SNYDER		4. DATE OF DEATH SEPTEMBER 19, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1899
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 19 IF UNDER 24 HRS. Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY HIGH SCHOOL	
11. BIRTHPLACE (County & State, or foreign country) ECKHART, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER W. SNYDER		14. MOTHER'S MAIDEN NAME ROSA MAY LANCASTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-10-2431	
17. INFORMANT MRS. ERVIN C. SNYDER		Address FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 153P IMMEDIATE CAUSE (a) Cancer of the Colon DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X	
20c. TIME OF INJURY Month, Day, Year 19 X Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) X (County) X (State) X	
21. I certify that (I) (this hospital) attended the deceased from JUNE, 1966 , to 9/19, 1967 , that (I) (we) last saw the deceased alive on 9/18, 1967 , and that death occurred at 3:50 AM , from causes and on the date stated above.			
22a. SIGNATURE Martin M. Rothstein		22b. DATE SIGNED 9/20/67	
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M.D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY ECKHART CEMETERY		23d. LOCATION (City or Town) (County) (State) ECKHART, ALLEGANY, MD.	
24. FUNERAL DIRECTOR M. SOWERS, HAFFER-SOWERS FUNERAL		25a. REC'D BY REGISTRAR SEP 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11308



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

11800

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11813

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10 Decatur Street</u>		d. STREET ADDRESS <u>10 Decatur Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura A. Wagoner Thomas</u>		4. DATE OF DEATH Month Day Year <u>September 3 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1892</u>
9. AGE (in years last birthday) <u>75</u> yrs.		10. BIRTHPLACE (County & State, or foreign country) <u>Hampshire Co. W. Va.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John Wagoner</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Milslagle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Howard E. Cooper, 1424 Magnolia Court</u>		Address <u>Cumberland, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Thrombosis</u> DUE TO (b) <u>Myocardial Infarction Acute</u> DUE TO (c) <u>Coronary Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I (this hospital) attended the deceased from <u>June 1964</u> to <u>Sept 3, 1967</u> , that I (we) last saw the deceased alive on <u>July 10 19 67</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Clay E. Durrett</u>		22b. DATE SIGNED <u>9/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Clay E. Durrett</u>		22d. ADDRESS <u>236 Virginia Ave., Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/6/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Near Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR <u>John J. Hafer, Jr., 230 Balto Ave., Baltimore, Md</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Hafer</u>			

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OFFICE OF THE

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11801

CERTIFICATE OF DEATH

11814

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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90

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1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN b. 7/7/1967 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 134 Elder Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Blanche Middle E. Last Tingler		4. DATE OF DEATH Month September Day 14 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/15/1878
9. AGE (In years at birthday) 89 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. Warner		14. MOTHER'S MAIDEN NAME Mary Elizabeth Teeter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT P.O. Box 599, Cumberland, Md. 21502 Allegany County Infirmary records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene, Rt. foot DUE TO (b) Chr. A.S.H.D. with Hypertension DUE TO (c) Arterio sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. many years many years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/7/67 , to 9/14/67 , that (I) (we) last saw the deceased alive on 9/14/67 , and that death occurred at P. M. from causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED 9/15/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/17/67	23c. NAME OF CEMETERY OR CREMATORY North Fork Memo Cem. Riverton N. Va	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md		25a. REC'D BY REGISTRAR SEP 18 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

1901

STATE OF DEATH

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany County, West Virginia

Allegany County, West Virginia

Allegany

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

11802

CERTIFICATE OF DEATH

11815

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 9/24/1966	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 218 N. Centre Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Leta Ann Troll		4. DATE OF DEATH Month Day Year September 21, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/1882
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Riley		14. MOTHER'S MAIDEN NAME Margaret Mellott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT P.O. Box 599, Cumberland, Md. 21502		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure DUE TO (b) Chr. A.S.H.D. DUE TO (c) Squid Arterio Sclerosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Squid Arterio Sclerosis - Metabolic toxins	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/24/1966 , 19 66 , to 9/21/1967 19 67 , that (I) (we) last saw the deceased alive on 9/21/1967 19 67 , and that death occurred at P. M, from causes and on the date stated above.			
22a. SIGNATURE John A. Topper, M.D.		22b. DATE SIGNED 9/22/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M.D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/25/67	
23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cn.		23d. LOCATION (City or Town) (County) (State) Cumberland Md.	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		25a. REC'D BY REGISTRAR DATE SEP 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11303

UNITED STATES OF AMERICA

Allegany County, Maryland

Witnessed and Subscribed

Allegany County, Maryland

John A. Thompson, Sheriff

Female, white, born [illegible]

Hennsville, Maryland

John Wiley

Marjorie M. Hallett

Allegany County, Maryland

John A. Thompson, Sheriff

Marjorie M. Hallett

Allegany County, Maryland

John A. Thompson, Sheriff

Allegany County, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

11802		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		11816	
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/19/67		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary				d. STREET ADDRESS 902 Michigan Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Garrett Middle R. Last Twigg				4. DATE OF DEATH Month September Day 24 Year 19 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/17/1890	
9. AGE (In years birth day) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Farming		10b. KIND OF BUSINESS OR INDUSTRY Laborer-Orchard		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Charles F. Twigg			
14. MOTHER'S MAIDEN NAME Hannah Goldsborough				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO.				17. INFORMANT P.O. Box 599, Cumberland, Md. 21502 Allegany County Infirmary records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 9/19/67 (b) 9/24/67 DUE TO 9/24/67 (c) 9/24/67 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/19/67 , 19__, to 9/24/67 , 19__, that (I) (we) last saw the deceased alive on 9/24/67 , 19__, and that death occurred at A. M. , from causes and on the date stated above.							
22a. SIGNATURE George M. Simons				22b. DATE SIGNED 9/25/1967			
22c. PHYSICIAN'S NAME (Type) George M. Simons, M. D.				22d. ADDRESS Memorial Hospital, Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 26, 1967		23c. NAME OF CEMETERY OR CREMATORY Wilson Cemetery		23d. LOCATION (City or Town) (County) (State) Near Oldtown, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR SEP 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

11802

Allegany

Allegany

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Allegany County Jail

Allegany County Jail

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FOR STATE
HEALTH DEPT.

11804

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11817

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Bedford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS Rural - Atremas	
3. NAME OF DECEASED (Type or print) First Milton Middle NMI Last Vance		4. DATE OF DEATH Month September Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1911
9. AGE (In years lost birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 13 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LINEMAN		10b. KIND OF BUSINESS OR INDUSTRY Telephone	
11. BIRTHPLACE (State or foreign country) West Virginia (Onego)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac P. Vance		14. MOTHER'S MAIDEN NAME Martha E. Habogast	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Pearl Vance, R.D. Artemas, Penna.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBDURAL-SUBARACHNOID HEMORRHAGE 13 days DUE TO (b) CONTUSIONS OF BRAIN DUE TO (c) 902.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 13 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off porch at home	
20c. TIME OF INJURY Month, Day, Year Hour 3:00 Min. 00 PM Sept. 13 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Artemas, Bedford, Penna	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED September 26, 1967		Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-29-67	
23c. NAME OF CEMETERY OR CREMATORY Fairview Christian Cem.		23d. LOCATION (City or Town) (County) (State) Mann Twp., Bedford, Pa.	
24. FUNERAL DIRECTOR John J. Hafner, Jr.		25a. REC'D BY REGISTRAR SEP 28 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11889



[The main body of the document contains several lines of extremely faint, illegible text, likely bleed-through from the reverse side. Some fragments are visible, such as "UNITED STATES OF AMERICA" and "DEPARTMENT OF THE ARMY".]

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
11805		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		11818	
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Hudson		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jersey City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 2695 Kennedy Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle Gabriel Last Walsh			4. DATE OF DEATH Month Sept. Day 16 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1943	9. AGE (In years last birthday) yrs. 24	IF UNDER 1 YEAR Months 16 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transit engineer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Jersey City, N. J.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Joseph Walsh		
14. MOTHER'S MAIDEN NAME Ruth Galvin			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown		
16. SOCIAL SECURITY NO. 148-32-9975			17. INFORMANT Address Jersey City, N.J. Routh Funeral Home 202 Old Bergen Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8254 IMMEDIATE CAUSE (a) CRUSHED CHEST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (AUTOMOBILE ACCIDENT) DUE TO (c) SUDDEN					INTERVAL BETWEEN ONSET AND DEATH --
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of vehicle in one car accidnet			
20c. TIME OF INJURY Month, Day, Year 12:25 a.m. Sept. 16 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 226 S. of Pa. line, Allegany, Md.	
20f. (City or town) (County) (State) Allegany, Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED September 16, 1967	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 16, 1967	
Address (Street, city, town, or county) Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/19/67		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
23d. LOCATION (City or Town) (County) (State) North Arlington, Bergen, N. J.					
24. FUNERAL DIRECTOR H. Wayne George 202 Greene St. Cumberland, Md.		25a. REC'D BY REGISTRAR DATE SEP 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

11805

1

Vehicle in one car accident

12-10-67

250

X

X

10-10-67

10-10-67

10-10-67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11806

CERTIFICATE OF DEATH

11819

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b D O A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART		d. STREET ADDRESS ROUTE 5, CUMBERLAND 2003 SEFON*BR**CUMB**MD.	
3. NAME OF DECEASED (Type or print) RETTA J. WARNER		4. DATE OF DEATH Month 09 Day 10 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/1883
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 09 Days 10 Hours 10 Min. 67	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) PENDLETON CO. W. VA.		13. CITIZEN OF WHAT COUNTRY? U S A	
14. FATHER'S NAME JOHN AD HARPER		15. MOTHER'S MAIDEN NAME SUSAN HARMAN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		17. SOCIAL SECURITY NO. 217-54-6403	
18. INFORMANT FRED WARNER, JR., ROUTE 5, CUMBERLAND MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary sclerosis DUE TO (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years 1 year 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) degenerative arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-2- , 19 64 , to 9-10 , 19 67 , that (I) (we) last saw the deceased alive on 9-10 , 19 67 , and that death occurred at 5:00 M, from causes and on the date stated above.			
22a. SIGNATURE L. Brings		22b. DATE SIGNED 9-11-67	
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.		22d. ADDRESS 57 GREENE STREET, CUMB., MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/13/67	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR SEP 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Yunge			

11302

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

CUMBERLAND

SACKED HEART

200-220-000, CUMBERLAND

RATT

WATER

0

10

7

WHITE

84

LEWIS GRASS, I.D.

27 GREENE STREET, I.D., NO. 21502

CERTIFICATE OF DEATH

11807

11820

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DOLLIE V WIGFIELD		4. DATE OF DEATH Month Day Year SEPT. 18 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-96 9. AGE (In years last birthday) 71 30 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KELLY STUMP		14. MOTHER'S MAIDEN NAME MYRTLE HENKEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crowning Thrombosis DUE TO (b) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 13, 1967 to Sept 14, 1967 , that (I) (we) last saw the deceased alive on Sept 13, 1967 and that death occurred at 8:15 AM , from causes and on the date stated above.			
22a. SIGNATURE B. M. Schindler M.D.		22b. DATE SIGNED 9/19/67	
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/21/67	23c. NAME OF CEMETERY OR CREMATORY Sunset Memo. Pk.	23d. LOCATION (City or Town) (County) (State) Cumberland, Alleg., Md.
24. FUNERAL DIRECTOR Philip B. Wendt ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE SEP 25 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11303

CERTIFICATE OF DEATH

ALLEGANY HANRYLAND ALLEGANY

CUMBERLAND, MO. S BAYS CUMBERLAND, MO.

MEMORIAL HOSPITAL 612 N. CENTRAL ST.

COLLIE V WICKFIELD SEPT. 18 67

REDALE WHITE 9-17-08

None None

WELLY STUMP MYRTLE HENRIEL

None None CUMBERLAND, MO. MEMORIAL HOSPITAL CUMBERLAND, MO.

DE. B. SCHINDLER CUMBERLAND, MO.

9/21/07 9/21/07

CUMBERLAND, MO.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

A34
10/1/67

11803

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11821

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 40 YEARS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS ROUTE 1, VALLEY ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DEWEY		4. DATE OF DEATH Month SEPT. Day 18 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 26, 1897
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACETONE WORKER		10b. KIND OF BUSINESS OR INDUSTRY CELANESE FIBERS CO.	
11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS WILFONG		14. MOTHER'S MAIDEN NAME LAVERNE HOSTETTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220 10 2449	
17. INFORMANT RETTA H. WILFONG		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- (c) ---			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.	
22. DATE SIGNED SEPTEMBER 18, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF SEPT. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY ZION MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	
25a. REC'D BY REGISTRAR DATE SEP 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

11803

James H. Taylor

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11808

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11822

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 2 FLINTSTONE, MD.			c. LENGTH OF STAY IN lb 6yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 2 FLINTSTONE, MD. 01-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WILLIAMS ROAD				d. STREET ADDRESS WILLIAMS ROAD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRIET L. WILSON				4. DATE OF DEATH Month SEPT. Day 14 Year 1967			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 15, 1873	
				9. AGE (In years lost birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR OCCUPATION HOUSEKEEPER		11. BIRTHPLACE (State or foreign country) NEAR FLINTSTONE, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS J. WILSON				14. MOTHER'S MAIDEN NAME ELIZABETH "ROBINETTE" WILSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-54-6296		17. INFORMANT MR FRED WILSON RFD 2 FLINTSTONE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS (c) SUDDEN						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				SEPTEMBER 13, 1967	
		Address (Street, city, town, or county) CUMBERLAND, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 16 SEPT 67		23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. CEMETERY		23d. LOCATION (City or Town) (County) (State) FLINTSTONE, MD. ALLEGANY MD.	
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR ST. CUMBERLAND, MD.				25a. REC'D BY REGISTRAR SEP 20 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

11808

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11810

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11823

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westernport		c. LENGTH OF STAY IN lb minutes	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		d. STREET ADDRESS Route 36 - 3 Mi. N. Westernport	
3. NAME OF DECEASED (Type or print) Joyce Ann WILSON		4. DATE OF DEATH Month Sept. Day 3 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1950
9. AGE (In years lost birthday) 17 yrs.		10. IF UNDER 1 YEAR Months 3 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY High School	
11. BIRTHPLACE (State or foreign country) Cumberland-Md. Allegany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert James Wilson		14. MOTHER'S MAIDEN NAME Eileen Bradley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert J. Wilson-Barton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 8254 IMMEDIATE CAUSE (a) Hemothorax, Perforated Right Lung DUE TO Crushed Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) " (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in Auto Accident	
20c. TIME OF INJURY Month, Day, Year Hour 7:50 a.m. Sept. 3 19 67 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 36; 2 miles south Barton, Allegany, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22. DATE SIGNED September 3, 1967 Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/7/67	
23c. NAME OF CEMETERY OR CREMATORY Rest Lawn		23d. LOCATION (City or Town) (County) (State) LaVale-Allegany Md.	
24. FUNERAL DIRECTOR E. J. Boal ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR SEP 8 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1110

Emmett Watson

SEP 8 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
11811										
11824										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,			c. LENGTH OF STAY IN 1b 9 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital					d. STREET ADDRESS 101 COLUMBIA ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First SARA Middle M Last WISE					4. DATE OF DEATH Month SEPT. Day 3 Year 19 67					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 9-27-1880		9. AGE (In years lost birthday) 86 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper- At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James T. McKnight					14. MOTHER'S MAIDEN NAME Anna V. Senate					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 470-34-0284		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO Arteriosclerosis (c) Arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 9 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Delayed diagnosis of Arteriosclerosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Cumbyville, Md.				
21. I certify that (I) (this hospital) attended the deceased from 8/25/67 to 9/3/67 , that (I) (we) last saw the deceased alive on 8/2/67 , and that death occurred at 7:53A , from causes and on the date stated above.										
22a. SIGNATURE [Signature]					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/4/67			
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS					22d. ADDRESS CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/5/67		23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery			23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland			
24. FUNERAL DIRECTOR H. Lee Silcox					ADDRESS Cumberland, Maryland 21502		25a. REC'D BY REGISTRAR SEP 6 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

1131

DEPARTMENT OF HEALTH

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND, MD.

2 DAYS

CUMBERLAND

101 COLUMBIA ST.

Medical Building

SEPT.

WIDE

STAIRS

FEMALE WHITE

9-27-20

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U.S.A.

WESTERN

Department of Health

State of Maryland

Department of Health

STATE OF MARYLAND

7-11-20

CUMBERLAND, MD.

D. F. WILLIAMS

SEP

1920

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FOR STATE HEALTH DEPT.

11812

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11825

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 144 GREEN STREET		d. STREET ADDRESS 144 GREEN STREET	
3. NAME OF DECEASED (Type or print) First MARY Middle YATES Last YATES		4. DATE OF DEATH Month SEPTEMBER Day 19 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 4, 1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-TEXTILE DEPT.		10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LOUIS RANK		14. MOTHER'S MAIDEN NAME ELIZABETH JENKINS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-28-6979	
17. INFORMANT HENRY YATES, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Sclerosis (c) Sudden		INTERVAL BETWEEN ONSET AND DEATH ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 9/19/67		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) RD 9 CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-22-67	23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR SEP 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11818

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11826

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 35 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. STREET ADDRESS 813 BRADDOCK ROAD	
3. NAME OF DECEASED (Type or print) First DOROTHY Middle R. Last YOUNG		4. DATE OF DEATH Month SEPT. Day 4 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH JULY 29, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	9. AGE (In years lost birthday) yrs. 58
11. BIRTHPLACE (State or foreign country) KITZMILLER, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROY O. RAFTER		14. MOTHER'S MAIDEN NAME MARGARET GRIMM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. GAIL GOLLADAY		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4431 IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic, M.D.		22. DATE SIGNED September 4, 1967	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF SEPT. 7, 1967	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR SEP 11 1967	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

11818

James M. [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11814

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11827

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BLAIR		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOLLIDAYSBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. MEMORIAL HOSPITAL				d. STREET ADDRESS 520 CLARK STREET	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES S. ZEEK			4. DATE OF DEATH Month Day Year SEPT. 18 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 28, 1907		9. AGE (In years lost birthday) yrs. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOILER WORKER		10b. KIND OF BUSINESS OR INDUSTRY BOILER		11. BIRTHPLACE (State or foreign country) HOLLIDAYSBURG PA.	
13. FATHER'S NAME PETER ZEEK			14. MOTHER'S MAIDEN NAME ANNA "STENGER" ZEEK		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 211-07-1291		17. INFORMANT JAMES ZEEK JR. DUCANSVILLE PA RFD#2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION, LEFT DUE TO (b) CORONARY THROMBOSIS, LEFT DUE TO (c) CORONARY SCLEROSIS, MARKED					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22. DATE SIGNED September 18, 1967 Address (Street, city, town, or county) CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 21, 1967	23c. NAME OF CEMETERY OR CREMATORY PRESBYTERIAN CEMETERY		23d. LOCATION (City or Town) (County) (State) HOLLIDAYSBURG BLAIR PA.
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND MARYLAND			25a. REC'D BY REGISTRAR DATE SEP 20 1967		
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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